

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9203

CERTIFICATE OF DEATH

09177

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ohio b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elyria	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 371 North Abbe Road	
3. NAME OF DECEASED (Type or print) First Donald Middle Ray Last Adams, Jr.		4. DATE OF DEATH Month August Day 21 , Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 2, 1955
9. AGE (In years last birthday) 3 yrs		10. IF UNDER 1 YEAR Months 6 Days 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Donald R. Adams, Sr.		14. MOTHER'S MAIDEN NAME Marcella Wright	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute Lymphoblastic Leukemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 4 mos.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from June 19, 19 58 to August 21, 19 58 , that I last saw the deceased alive on August 21, 19 58 , and that death occurred at 9:30 A. from the causes and on the date stated above.			
ACTUAL SIGNATURE G. Richard Lee		DATE SIGNED 8/21/58	
PHYSICIAN'S NAME (Type) G. Richard Lee, M. D.		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/24/58	22c. NAME OF CEMETERY OR CREMATORY Private Cemetery	22d. LOCATION (City, town, or county) (State) Jackhorn, Kentucky
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR AUG 22 58		24b. REGISTRAR'S SIGNATURE Arthur S. House	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10777

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		35		Jan 15, 1900		West Virginia	
Cause of Death		Manner of Death		Occupation		Residence		County	
Heart Disease		Natural		Farmer		Farmington, W. Va.		Mingo	
Physician		Burial		Interment		Date of Death		Time of Death	
Dr. J. H. Smith		Buried		Buried		Jan 20, 1935		10:00 AM	
Signature of Physician		Signature of Registrar		Signature of Minister		Signature of Coroner		Signature of Jury	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
The Official Seal of the State of West Virginia		The Official Seal of the County of Mingo		The Official Seal of the City of Farmington		The Official Seal of the Town of [Blank]		The Official Seal of the Village of [Blank]	
[Seal]		[Seal]		[Seal]		[Seal]		[Seal]	

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS

9178

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>4 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hospital</u>				e. STREET ADDRESS <u>6729 Piney Br. Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>Isabella (NMN.) Alexander</u>				4. DATE OF DEATH <u>Aug. 12 1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-25-74</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Scotland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>	
13. FATHER'S NAME <u>Alexander Davidson</u>				14. MOTHER'S MAIDEN NAME <u>Susan Angus</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Son</u>			
17. INFORMANT <u>10023 Greenock Rd. SS., Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage c.</u> 331X DUE TO <u>Aphasia & Left Hemiplegia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterial Hypertension</u> DUE TO (c) <u>Generalized Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>Undetermined</u> <u>Undetermined</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan 1, 1952</u> to <u>Aug 12, 1958</u> , that I last saw the deceased alive on <u>Aug 11, 1958</u> , and that death occurred at <u>3:02 p.m.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George L. Ball</u> M.D.				ADDRESS (Street, city or town, state) <u>2835 Eastern Ave. Silver Spring Md.</u>			
PHYSICIAN'S NAME (Type) <u>George L. Ball</u>				DATE SIGNED <u>Aug 14 58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 15, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u> ADDRESS <u>254 Canal St NW 20C</u>				24a. REG'D BY REGISTRAR <u>Aug 14 58</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician or completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1005

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician or completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 09179

9204

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>MONTG.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 TAKOMA PARK</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KENSINGTON GARDENS SANITARIUM</u>				d. STREET ADDRESS <u>7419 PINEY BRANCH RD</u>			
3. NAME OF DECEASED (Type or print) First <u>DORA</u> Middle <u>ANDERSON</u> Last <u>ANDERSON</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>1</u> Year <u>1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 31, 1874</u>	9. AGE (In years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR Months <u>2</u> Days <u>10</u> Hours <u>40</u> Min.		IF UNDER 24 HRS. Hours <u>40</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOMEMAKER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>KENTUCKY</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>BARTON LOWE</u>			
14. MOTHER'S MAIDEN NAME <u>MARTHA</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>MRS IRENE BRUNGART</u> Address <u>7419 PINEY BRANCH RD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis Generalized Senile</u> DUE TO <u>10 years</u> (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cholelithiasis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>o. 11</u> Month <u>19</u> Day <u>19</u> Year <u>1958</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>April</u> , 1958, to <u>1 Aug</u> , 1958, that I last saw the deceased alive on <u>31 July</u> , 1958, and that death occurred at <u>2:40 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>7112 Willow Ave</u>				ADDRESS (Street, city or town, state) <u>1 Aug</u>			
PHYSICIAN'S NAME (Type) <u>H. B. QUEEN</u>				DATE SIGNED <u>Takoma Park Md</u> <u>1958</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>AUG 3 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HANOVER CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MORRISTOWN, INDIANA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>254 Small St</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 4 1958</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

CERTIFICATE OF DEATH

1910

1. Name of deceased: *John Doe*
2. Sex: *Male*
3. Age: *45*
4. Date of death: *Jan 15 1910*
5. Place of death: *Home*
6. Cause of death: *Heart Disease*
7. Duration of illness: *2 weeks*
8. Name of physician: *Dr. J. H. Smith*
9. Name of attending nurse: *Miss Mary Jones*
10. Name of undertaker: *Mr. W. H. Brown*

11. Name of informant: <i>John Doe</i>		12. Signature of informant: <i>[Signature]</i>	
13. Name of registrar: <i>John Doe</i>		14. Signature of registrar: <i>[Signature]</i>	
15. Name of physician: <i>Dr. J. H. Smith</i>		16. Signature of physician: <i>[Signature]</i>	
17. Name of attending nurse: <i>Miss Mary Jones</i>		18. Signature of attending nurse: <i>[Signature]</i>	
19. Name of undertaker: <i>Mr. W. H. Brown</i>		20. Signature of undertaker: <i>[Signature]</i>	
21. Name of funeral home: <i>Mr. W. H. Brown</i>		22. Signature of funeral home: <i>[Signature]</i>	
23. Name of cemetery: <i>St. Mary's</i>		24. Signature of cemetery: <i>[Signature]</i>	
25. Name of church: <i>St. Mary's</i>		26. Signature of church: <i>[Signature]</i>	
27. Name of minister: <i>Rev. J. H. Smith</i>		28. Signature of minister: <i>[Signature]</i>	
29. Name of pastor: <i>Rev. J. H. Smith</i>		30. Signature of pastor: <i>[Signature]</i>	
31. Name of sexton: <i>Mr. W. H. Brown</i>		32. Signature of sexton: <i>[Signature]</i>	
33. Name of sexton: <i>Mr. W. H. Brown</i>		34. Signature of sexton: <i>[Signature]</i>	
35. Name of sexton: <i>Mr. W. H. Brown</i>		36. Signature of sexton: <i>[Signature]</i>	
37. Name of sexton: <i>Mr. W. H. Brown</i>		38. Signature of sexton: <i>[Signature]</i>	
39. Name of sexton: <i>Mr. W. H. Brown</i>		40. Signature of sexton: <i>[Signature]</i>	
41. Name of sexton: <i>Mr. W. H. Brown</i>		42. Signature of sexton: <i>[Signature]</i>	
43. Name of sexton: <i>Mr. W. H. Brown</i>		44. Signature of sexton: <i>[Signature]</i>	
45. Name of sexton: <i>Mr. W. H. Brown</i>		46. Signature of sexton: <i>[Signature]</i>	
47. Name of sexton: <i>Mr. W. H. Brown</i>		48. Signature of sexton: <i>[Signature]</i>	
49. Name of sexton: <i>Mr. W. H. Brown</i>		50. Signature of sexton: <i>[Signature]</i>	
51. Name of sexton: <i>Mr. W. H. Brown</i>		52. Signature of sexton: <i>[Signature]</i>	
53. Name of sexton: <i>Mr. W. H. Brown</i>		54. Signature of sexton: <i>[Signature]</i>	
55. Name of sexton: <i>Mr. W. H. Brown</i>		56. Signature of sexton: <i>[Signature]</i>	
57. Name of sexton: <i>Mr. W. H. Brown</i>		58. Signature of sexton: <i>[Signature]</i>	
59. Name of sexton: <i>Mr. W. H. Brown</i>		60. Signature of sexton: <i>[Signature]</i>	
61. Name of sexton: <i>Mr. W. H. Brown</i>		62. Signature of sexton: <i>[Signature]</i>	
63. Name of sexton: <i>Mr. W. H. Brown</i>		64. Signature of sexton: <i>[Signature]</i>	
65. Name of sexton: <i>Mr. W. H. Brown</i>		66. Signature of sexton: <i>[Signature]</i>	
67. Name of sexton: <i>Mr. W. H. Brown</i>		68. Signature of sexton: <i>[Signature]</i>	
69. Name of sexton: <i>Mr. W. H. Brown</i>		70. Signature of sexton: <i>[Signature]</i>	
71. Name of sexton: <i>Mr. W. H. Brown</i>		72. Signature of sexton: <i>[Signature]</i>	
73. Name of sexton: <i>Mr. W. H. Brown</i>		74. Signature of sexton: <i>[Signature]</i>	
75. Name of sexton: <i>Mr. W. H. Brown</i>		76. Signature of sexton: <i>[Signature]</i>	
77. Name of sexton: <i>Mr. W. H. Brown</i>		78. Signature of sexton: <i>[Signature]</i>	
79. Name of sexton: <i>Mr. W. H. Brown</i>		80. Signature of sexton: <i>[Signature]</i>	
81. Name of sexton: <i>Mr. W. H. Brown</i>		82. Signature of sexton: <i>[Signature]</i>	
83. Name of sexton: <i>Mr. W. H. Brown</i>		84. Signature of sexton: <i>[Signature]</i>	
85. Name of sexton: <i>Mr. W. H. Brown</i>		86. Signature of sexton: <i>[Signature]</i>	
87. Name of sexton: <i>Mr. W. H. Brown</i>		88. Signature of sexton: <i>[Signature]</i>	
89. Name of sexton: <i>Mr. W. H. Brown</i>		90. Signature of sexton: <i>[Signature]</i>	
91. Name of sexton: <i>Mr. W. H. Brown</i>		92. Signature of sexton: <i>[Signature]</i>	
93. Name of sexton: <i>Mr. W. H. Brown</i>		94. Signature of sexton: <i>[Signature]</i>	
95. Name of sexton: <i>Mr. W. H. Brown</i>		96. Signature of sexton: <i>[Signature]</i>	
97. Name of sexton: <i>Mr. W. H. Brown</i>		98. Signature of sexton: <i>[Signature]</i>	
99. Name of sexton: <i>Mr. W. H. Brown</i>		100. Signature of sexton: <i>[Signature]</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9205 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09180

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mntg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN TB <u>6 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2800 Jutland Rd</u>				d. STREET ADDRESS <u>2800 Jutland Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Othelia Dressel Anderson</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>3</u> Year <u>1958</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-24-1888</u>		9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Del</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Peter Dressel</u>				14. MOTHER'S MAIDEN NAME <u>Matilda Pankin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>122-09-2740</u>		17. INFORMANT <u>B. D. Anderson (husband)</u> Address <u>2800 Jutland Rd. Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Congestive heart disease</u> <u>434.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Abdominal Aortic</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							INITIAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>3 days</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Brosch</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>8-3-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/6/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter C. Humphrey</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 5 58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. C. Humphrey</u>			

MEDICAL CERTIFICATION

2

STATE OF
MASSACHUSETTS

DEPARTMENT OF HEALTH

REGISTRATION

MASSACHUSETTS

STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(10114)

1. Name of deceased: *John Doe*
2. Age: *45*
3. Sex: *Male*
4. Date of death: *Jan 15, 1910*
5. Place of death: *Home*
6. Cause of death: *Heart Disease*
7. Manner of death: *Natural*
8. Signature of Medical Examiner: *J. A. Smith*
9. Signature of Registrar: *M. B. Jones*
10. Date of registration: *Jan 16, 1910*

11. Name of informant: *John Doe*
12. Address of informant: *123 Main St, Boston*
13. Signature of informant: *J. Doe*
14. Date of information: *Jan 15, 1910*

9206

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Fauquier	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 38 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mason Middle Fitzhugh Last Ball		4. DATE OF DEATH Month August Day 17 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 28, 1897
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sanitation Inspector		10b. KIND OF BUSINESS OR INDUSTRY Sanitation	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles F. Ball		14. MOTHER'S MAIDEN NAME Bessie Scott	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) yes WW I		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Portal Vein Thromboses with infarction of bowel DUE TO (b) Status post splenectomy for splenomegaly DUE TO (c) Amyogenic myeloid metaplasia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Uremia, Renal lithiasis, shock		INTERVAL BETWEEN ONSET AND DEATH 4 days 12 days 10 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 10, 1958 , to August 17, 1958 , that I last saw the deceased alive on August 17, 1958 , and that death occurred at 6:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 8-18-58 ACTUAL SIGNATURE Norman R. Gevertz M.D. National Institutes of Health PHYSICIAN'S NAME (Type) Norman R. Gevertz, M.D. Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) removal		22b. DATE THEREOF 8/20/58	
22c. NAME OF CEMETERY OR CREMATORY Ivy Hill Cemetery		22d. LOCATION (City, town, or county) (State) Upperville, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		24a. REC'D BY REGISTRAR 2901 14th St. N.W. Washington 9, D.C.	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		DATE AUG 20 '58	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Date of death: _____

6. Place of death: _____

7. Cause of death: _____

8. Signature of physician: _____

9. Signature of registrar: _____

10. Date of registration: _____

9208

CERTIFICATE OF DEATH

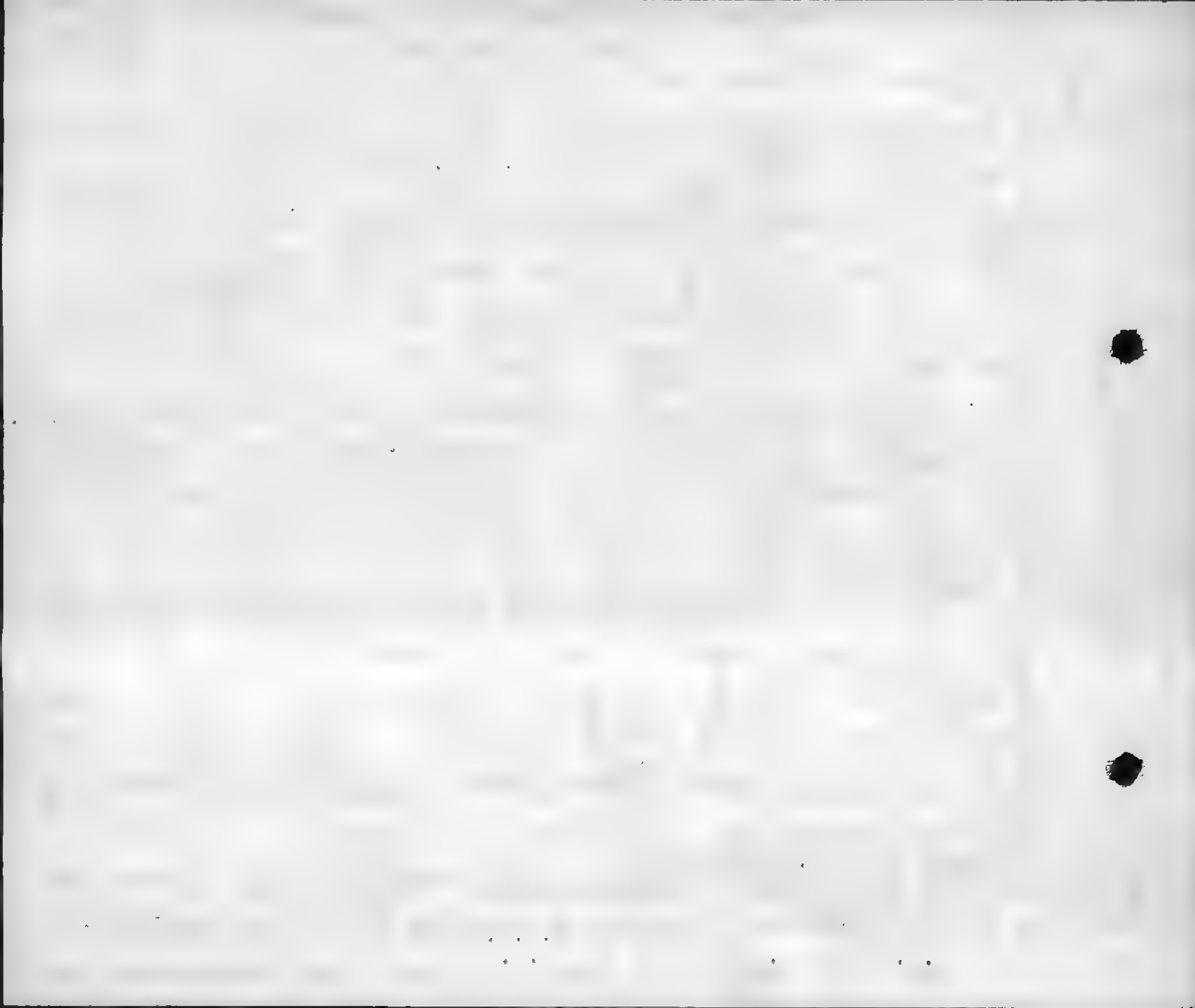
09183

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4707 Chevy Chase Drive</u>		d. STREET ADDRESS <u>4707 Chevy Chase Drive</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Muriel Catherine Barnes</u>		4. DATE OF DEATH Month Day Year <u>Aug 8 1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 8, 1896</u>
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life) even if retired <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Amberson C. Hardy</u>		14. MOTHER'S MAIDEN NAME <u>Mary Walstrom</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Henry B. Barnes</u>		Address <u>Chevy Chase, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of ovary, with metastases</u> DUE TO (b) <u>1750</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>1 yr.</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>October 1957</u> to <u>Aug 8 1958</u> , that I last saw the deceased alive on <u>Aug 7 1958</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James M. Whitlock</u> M.D.		ADDRESS (Street, city or town, state) <u>7701 Cavall Drive</u> DATE SIGNED <u>8-8-58</u>	
PHYSICIAN'S NAME (Type) <u>James M. Whitlock</u>		<u>ThKome Park 12 Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/11/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>		ADDRESS <u>Wash. D.C.</u>	24a. REC'D BY REGISTRAR <u>Aug 11 '58</u>
24b. REGISTRAR'S SIGNATURE <u>W. H. Hines</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is completely filled in by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon copy and return it to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 09182

9207

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>	
c. LENGTH OF STAY IN 1b <u>3 months</u>		d. STREET ADDRESS <u>3412 Rittenhouse St. N.W.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Resmor Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Archy</u> Middle <u>Wright</u> Last <u>Barnes</u>		4. DATE OF DEATH Month <u>August</u> Day <u>26</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 21, 1891</u>
9. AGE (In years lost birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>8</u> Days <u>5</u> Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>naval officer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt. supply</u>	
11. BIRTHPLACE (State or foreign country) <u>Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Oscar O. Barnes</u>		14. MOTHER'S MAIDEN NAME <u>Frances Wright</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>1898-1935</u>		16. SOCIAL SECURITY NO. <u>1898-1935</u>	
17. INFORMANT <u>daughter</u> Address <u>Bethesda, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiovascular collapse</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>generalized arteriosclerosis</u> DUE TO (c) <u>5-10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>cerebral arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>9</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept</u> , 19 <u>56</u> , to <u>August</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>August 14</u> , 19 <u>58</u> , and that death occurred at <u>5:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4890 Battery Lane, Bethesda</u> DATE SIGNED <u>8/26/58</u>			
ACTUAL SIGNATURE <u>Wilfred R. Hermantant</u> M.D.		PHYSICIAN'S NAME (Type) <u>Wilfred R. Hermantant M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/29/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 28 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraw</u>			



9209

Item 2, 4, 7, 10, 12, 18-20, 21 et

CERTIFICATE OF DEATH

Reg. Dist. No. 09184

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN TB <u>3 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Walter Houston Bearden</u>		4. DATE OF DEATH <u>8 14 1958</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 9 1882</u>
9. AGE (In years last birthday) <u>76 1/2 yrs.</u>		10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dispatcher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>A. & N. Railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>Alabama</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Samuel H. Bearden</u>		14. MOTHER'S MAIDEN NAME <u>Louise Payne</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Wife Mrs. William Bearden Same</u>	
17. INFORMANT <u>Wife Mrs. William Bearden</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia Terminal</u>		<u>1 day</u>	
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) <u>Coronary Occlusion & Infarction</u>	
DUE TO		<u>48 hr.</u>	
(c) <u>arterio Sclerosis generalized</u>		<u>10 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<u>Hemiplegia</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>16 July, 1958</u> , to <u>date</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>14 Aug.</u> , 19 <u>58</u> , and that death occurred at <u>4:05</u> M, from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <u>John G. Ball</u> M.D. <u>7936 Georgetown Rd.</u>		<u>14 Aug 58</u>	
PHYSICIAN'S NAME (Type) <u>John G. Ball</u>		<u>Bethesda, 14 Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>8/16/58</u>	<u>Parklawn cem.</u>	<u>Rodman Pike Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE		24. REGISTRY REGISTRAR	24b. REGISTRAR'S SIGNATURE
<u>Cherry Chase Funeral Home, N.W. Thurgood</u>		<u>AUG 18 '58</u>	<u>Arthur S. Hume</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9210

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Olney</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Brooke Grove Foundation</i>		d. STREET ADDRESS <i>804 Maplewood Ave.</i>	
3. NAME OF DECEASED (Type or print) <i>Wilhelmina Bauer Becker</i>		4. DATE OF DEATH <i>Aug. 6 1958</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 2. 1879</i>
9. AGE (In years last birthday) <i>78</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>North Dakota</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John Bauer</i>		14. MOTHER'S MAIDEN NAME <i>Katherine Yungert</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Hospital Records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: - - - X IMMEDIATE CAUSE (a) <i>Congestive heart failure</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Septicemia</i> DUE TO (c) <i>Acute cholecystitis</i>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Generalized arteriosclerosis</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>6/16</i> , 19 <i>58</i> , to <i>8/6</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>8/6</i> , 19 <i>58</i> , and that death occurred at <i>7:45</i> p.m., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Eino Magi</i>		DATE SIGNED <i>8/6/58</i>	
PHYSICIAN'S NAME (Type) <i>EINO MAGI</i>		ADDRESS (Street, city or town, state) <i>918 Univ. Blvd. E., Silver Spring, Maryland</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>Aug 10-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Beltside Cemetery</i>	22d. LOCATION (City, town or county) (State) <i>Beltside, Canada</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur Walters</i>		24. REC'D BY REGISTRAR <i>REC'D</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur Walters</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is to be used for the funeral director's permit. Page 3 should be detached and used for the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9179

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

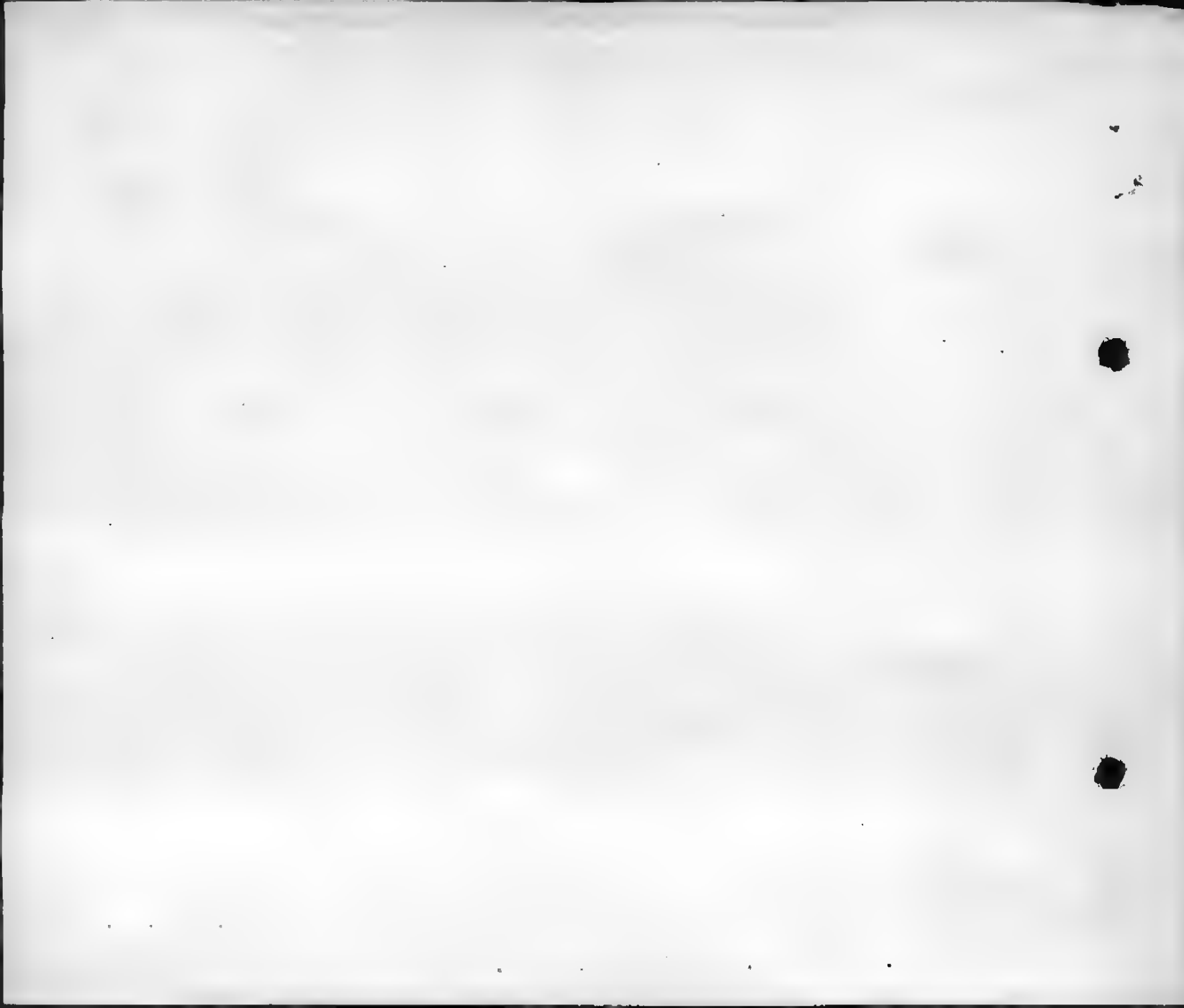
Items 7 & 8, Film G-233 8/29/58.cnc.

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
c. LENGTH OF STAY IN 1b <u>17 yrs</u>		d. STREET ADDRESS <u>7216 Willow Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7216 Willow Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Caroline Gibson Berry</u>		4. DATE OF DEATH <u>Aug 13 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>2-14-91</u>
9. AGE (in years last birthday) <u>67 yrs.</u>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C. Court</u>	
11. BIRTHPLACE (State or foreign country) <u>Wash D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Wm E Gibson</u>		14. MOTHER'S MAIDEN NAME <u>Mary I. Todd</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>5601 Col. Ave NW, Wash D.C.</u>	
17. INFORMANT <u>Mary Berry Kamm</u>		Address <u>5601 Col. Ave NW, Wash D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of stomach & liver</u> DUE TO (b) <u>with generalized metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		DATE SIGNED <u>8-13-58</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/15/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co. Washington, D. C.</u>		24b. REC'D BY REGISTRAR <u>Aug 15 '58</u>	
		24c. REGISTRAR'S SIGNATURE <u>William L. Hines</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove card papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9211

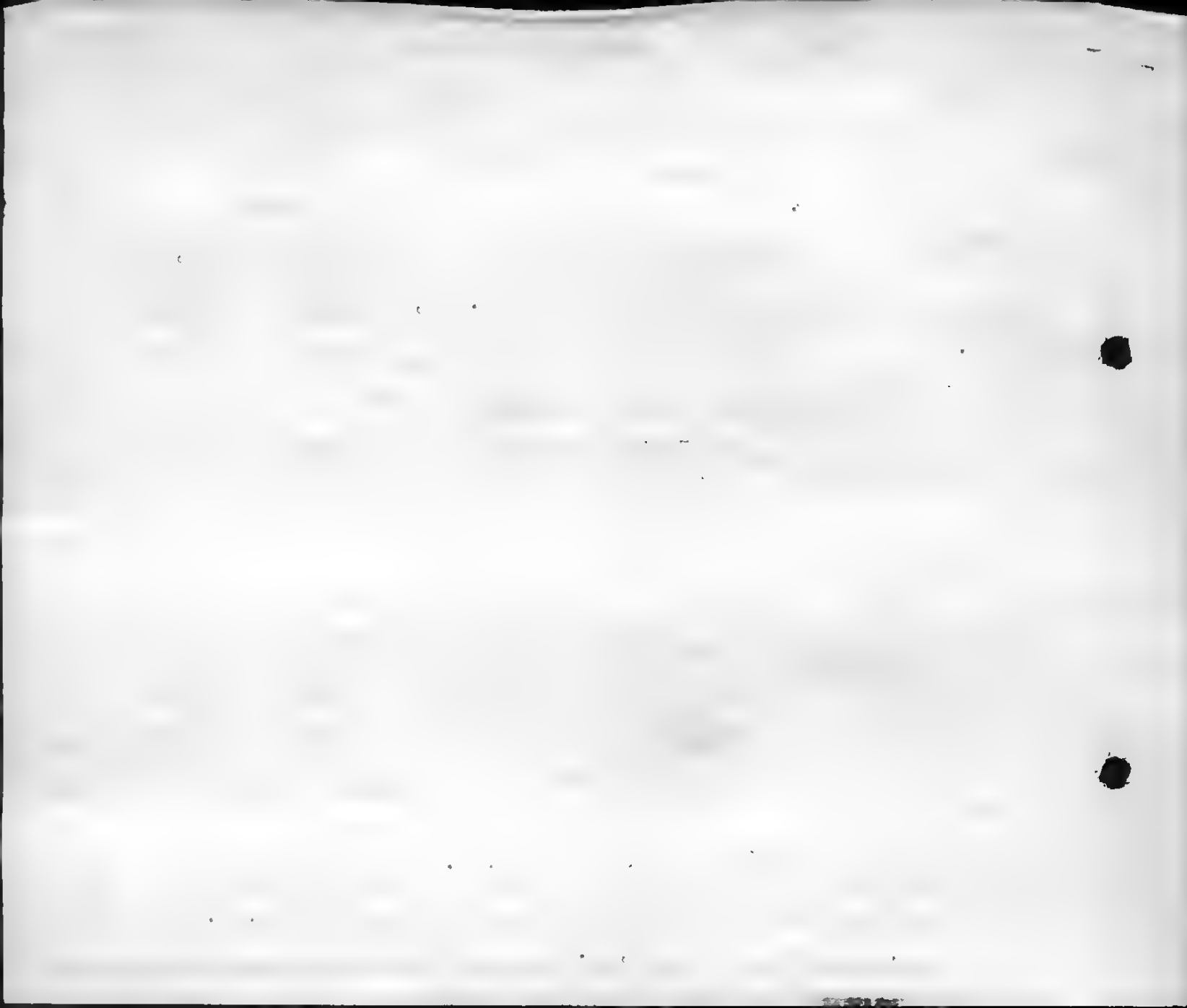
CERTIFICATE OF DEATH

09187

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5508 Oakmont Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM HERBERT BILlich				4. DATE OF DEATH Month Day Year August 13, 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 25, 1900	9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 10 18	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mgr.		10b. KIND OF BUSINESS OR INDUSTRY Engineer		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Daniel Billich				14. MOTHER'S MAIDEN NAME Sarah Miller			
15. WAS DECEASED EVER IN U. S. ARMY FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 187-09-3094		17. INFORMANT Address Mildred Billich-Item#2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 120.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial infarction DUE TO (c) Coronary atherosclerosis							INTERVAL BETWEEN ONSET AND DEATH 15 min. 1 hr. and 1/2
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Weakness, indigestion							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept. 1, 1951 , to 8/13/58 , that I last saw the deceased alive on 8/13/58 , and that death occurred at 11:00 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Stephen Jones 8/14/58 809 Viers Mill Road, Rockville, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/16/58		22c. NAME OF CEMETERY OR CREMATORY Parklawn		22d. LOCATION (City, town, or county) (State) Rockville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR AUG 15 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hous	

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9212 Item 19 1958-12-12-58 et
CERTIFICATE OF DEATH

09188

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 82 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 418 ✓			
				d. STREET ADDRESS 2110 F Street, N.W.			
3. NAME OF DECEASED (Type or print) First Ann Middle Regina Last Bishop				4. DATE OF DEATH Month August Day 12, Year 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 24, 1906		9. AGE (In years last birthday) 51 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John McCullough				14. MOTHER'S MAIDEN NAME Minnie Lynch			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 100-16-2772		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Brain metastasis - carcinoma of Cervix Uteri DUE TO (c) Carcinoma of Cervix Uteri							INTERVAL BETWEEN ONSET AND DEATH 15 min. 1 yr. 3 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 22, 19 58 to August 12, 19 58 , that I last saw the deceased alive on August 12, 19 58 , and that death occurred at 4:10A M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Marvin M. Ramsdahl</i> M.D.				ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 8/12/58			
PHYSICIAN'S NAME (Type) Marvin M. Ramsdahl, M. D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/14/58		22c. NAME OF CEMETERY OR CREMATORY N. H. Olcott		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Valley's Funeral Home, Inc.</i>				ADDRESS mt. Rainier, Md.		24a. REC'D BY REGISTRAR DATE AUG 18 '58	
				24b. REGISTRAR'S SIGNATURE <i>W. H. E. Evans</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is completely filled in by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

9213

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09189

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Montgomery County Gen. Hosp.		e. STREET ADDRESS RFD # 1	
3. NAME OF DECEASED (Type or print) Barry Dennis Boccabella		4. DATE OF DEATH Month Aug. Day 29 Year 1958	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/8/51
9. AGE (In years last birthday) 6 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY student	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Raymond G. Boccabella		14. MOTHER'S MAIDEN NAME Helen Irene Skelton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Hosp. Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral edema & laceration 919.0 DUE TO Conditions if any, which gave rise to immediate cause (b) Bullet wound thru skull (c) stating the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) INTERVAL BETWEEN ONSET AND DEATH 1 1/2 days N			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Playing with 32 cal. revolver	
20c. TIME OF INJURY Month, Day, Year 1:23 p.m. 8/27/58 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) (County) (State) Olney Montg. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		DATE SIGNED 8/29/58	
EXAMINER'S NAME (Type) Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF SEPT. 2, 1958	
22c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Rumphrey		24a. REC'D BY REGISTRAR SEP 2 1958	
ADDRESS SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE Charles L. House	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 1, 2, and 3 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



9214

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Potomac				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ropine Rest Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) FRANCES S. BOLTON				4. DATE OF DEATH August 27 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 26, 1884	
9. AGE (In years last birthday) 74 yrs.		10. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				11. BIRTHPLACE (State or foreign country) Maryland			
13. FATHER'S NAME John T. Sipes				14. MOTHER'S MAIDEN NAME Eliza Hill			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None			
17. INFORMANT Lewis Edward Bolton				Address Same as Item 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1561 DUE TO Respiratory Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Malnutrition (c) Cancer of the Liver INTERVAL BETWEEN ONSET AND DEATH 2 hrs. 2 mo. 3 mo.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 4/18, 1955 , to 8/27, 1958 , that I last saw the deceased alive on 8/21, 1958 , and that death occurred at 11:25 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Frank Jaggers - 5707 Wis. Av.e. Chevy Chase, Md. DATE SIGNED 8/28/58							
ACTUAL SIGNATURE Frank Jaggers M.D.				DATE SIGNED 8/28/58			
PHYSICIAN'S NAME (Type) Frank Jaggers - 5707 Wis. Av.e. Chevy Chase, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-30-58		22c. NAME OF CEMETERY OR CREMATORY Potomac Church Cem.		22d. LOCATION (City, town, or county) (State) Montgomery County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR SEP 2 '58	
				24b. REGISTRAR'S SIGNATURE Caribua S. King			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician of the deceased, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

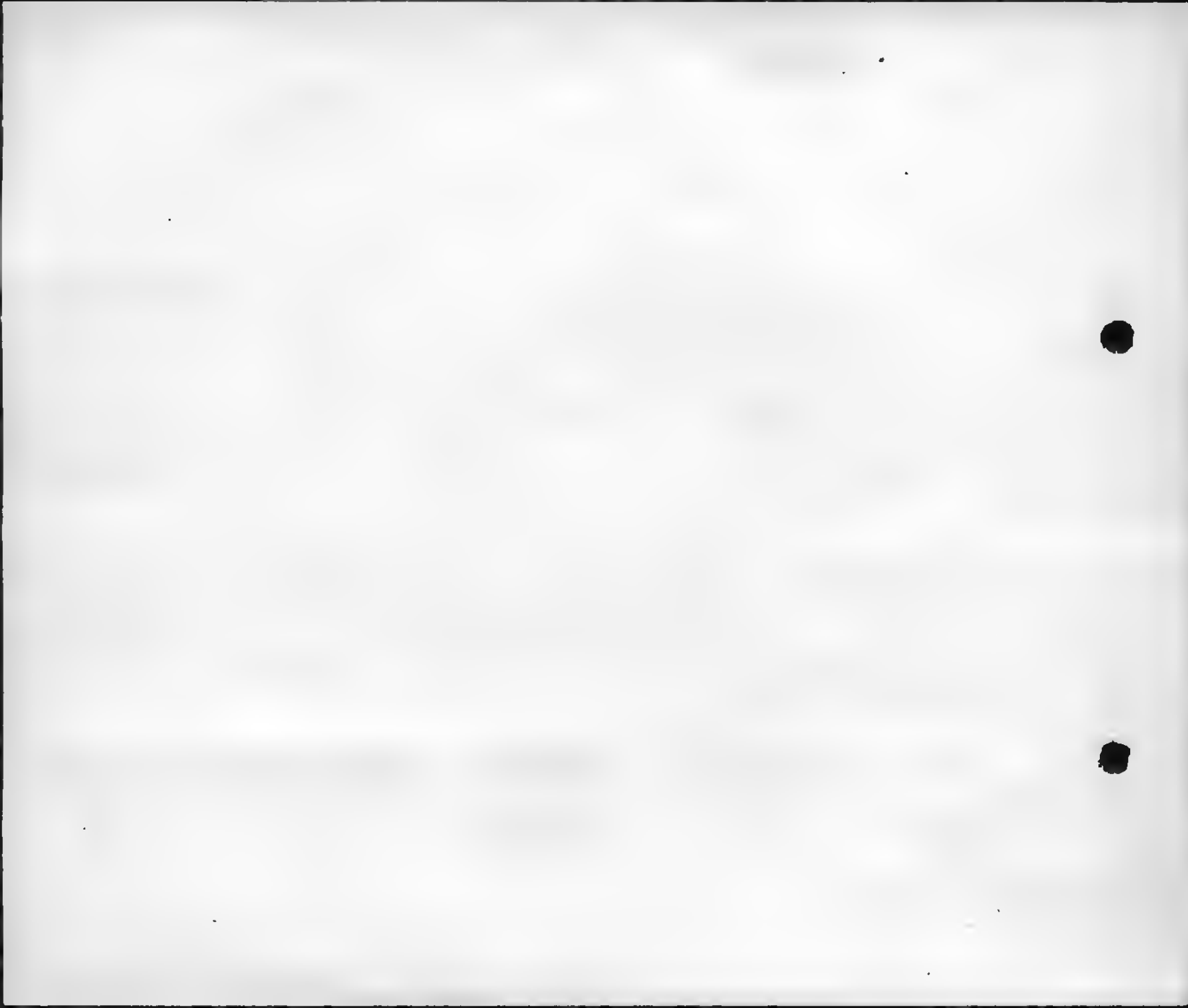
9215

CERTIFICATE OF DEATH

Reg. Dist. No.

09191

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevey Chase</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens Sanitarium</u>				d. STREET ADDRESS <u>13705 Spring Street</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Marion Eliot BRADFORD</u>				4. DATE OF DEATH Month Day Year <u>Aug 16 1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/22/1896</u>		9. AGE (In years lost birthday) <u>61</u> yrs	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Clinton, Mass</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Wm Stevenson</u>				14. MOTHER'S MAIDEN NAME <u>Mary M. Neily</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT Address <u>Nelson O. Bradford 3705 Spring St</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Uremia</u> <u>1812</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma Testis - Origin Bladder</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 12, 1958</u> to <u>Aug 16, 1958</u> that I last saw the deceased alive on <u>Aug 15, 1958</u> , and that death occurred at <u>1210 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>10609 CONCORD ST. Aug 16, 58</u>							
ACTUAL SIGNATURE <u>Robert T. Thibadeau</u>				PHYSICIAN'S NAME (Type) <u>ROBERT T. THIBADEAU KENSINGTON, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>8/19/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cms.</u>		22d. LOCATION (City, town, or county) (State) <u>Clinton, Mass</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Cherry Chase Funeral Home</u>				ADDRESS <u>5103 W. Ave Wash, D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>Aug 19 58</u>	
				24b. REGISTRAR'S SIGNATURE <u>C. L. Kraus</u>			



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9216 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09192

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>4919 Jamestown Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Maurice K. Brady</u>		4. DATE OF DEATH <u>8-28-1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 20, 1904</u>
9. AGE (In years last birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR <u>7</u> Months <u>7</u> Days <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manufacturers Rep Dugent Circle Bldg Connecticut</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S.A.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward J. Brady</u>		14. MOTHER'S MAIDEN NAME <u>Maudie Cleary</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>Charlotte Brady - Wife</u>	
17. INFORMANT <u>Charlotte Brady - Wife</u>		Address <u>Washington D.C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage & laceration</u> DUE TO (b) <u>Bullet wound thru skull</u> DUE TO (c) <u>Self-inflicted bullet wound thru skull</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1 hr 15 min.</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self-inflicted bullet wound thru skull</u>	
20c. TIME OF INJURY Month, Day, Year <u>5:15 p.m. 8-28-1958</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Washington D.C.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Brochant</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BROCHANT</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/30/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemt.</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOSEPH F. BIRCH'S SONS WASH. DC</u>		24a. REC'D BY REGISTRAR <u>SEP 2 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hays</u>		DATE <u>SEP 2 '58</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. File pages 1, 2, and 3 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



9217

CERTIFICATE OF DEATH

Reg. Dist. No.

09193

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Wash. D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>		d. STREET ADDRESS <u>3606 M^e Kinley St. N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Riley</u> Middle <u>Brown</u> Last		4. DATE OF DEATH <u>Aug. 24</u> 19 <u>58</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 29, 1867</u>
9. AGE (In years last birthday) <u>41</u> yrs		10. IF UNDER 1 YEAR: Months <u>24</u> Days <u>24</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newspaper work</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John(?) Brown</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Hospital records</u>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>urinary Tract hemorrhage</u> DUE TO (c) <u>debilitated condition</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>2 mos</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture right hip - left nephrectomy - Chronic sinusitis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>phlegma</u>

20c. TIME OF INJURY Month, Day, Year Hour a. p. <u>19</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
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21. I certify that I attended the deceased from May 28, 1958, to Aug 24, 1958, that I last saw the deceased alive on July 25, 1958, and that death occurred at 8:58 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE John R. Spencer M.D. ADDRESS (Street, city or town, state) DATE SIGNED 8-24-58

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>8-27-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CONGRESSIOAL</u>	22d. LOCATION (City, town, or county) (State) <u>WASH. D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James T. Ryan</u>		ADDRESS <u>317 Penn Ave</u>	24a. REC'D BY REGISTRAR <u>Aug 27 '58</u>
		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove and forward to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9218

CERTIFICATE OF DEATH

Reg. Dist. No.

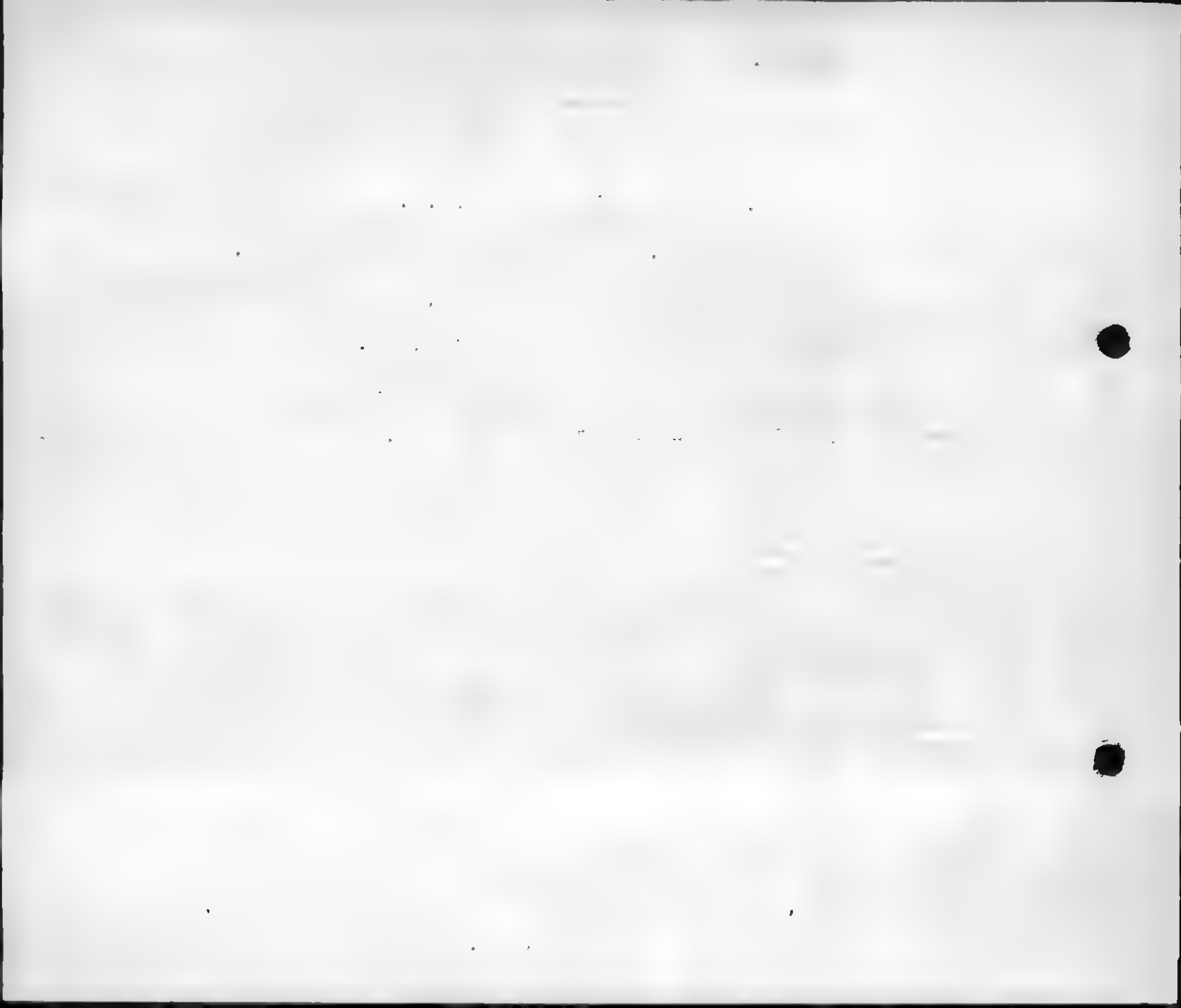
09194

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>1 week</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery Co. Gen. Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germantown</u>			
				d. STREET ADDRESS <u>R.F.D.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Paul L. Burdette</u>				4. DATE OF DEATH Month Day Year <u>Aug. 31 19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 25, 1898</u>		9. AGE (In years last birthday) <u>60</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own farm</u>		11. BIRTHPLACE (State or foreign country) <u>Boys, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard Burdette</u>				14. MOTHER'S MAIDEN NAME <u>Laura Lewis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) [If yes, give war or dates of service] <u>Yes</u> <u>1917-1918</u>		16. SOCIAL SECURITY NO. <u>215-36-4661</u>		17. INFORMANT Address <u>Mrs Bertha C. Burdette, Germantown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>LONG STANDING - ADVANCED RENAL TUBERCULOSIS</u> <u>NON-INFECTIOUS TERMINAL UREMIA</u> DUE TO <u>MULTIPLE RENAL CALCULI</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bimolecular uremia</u> DUE TO <u>Chronic glomerulonephritis</u> (c) <u>Modest cardiac hypertrophy</u>						INTERVAL BETWEEN ONSET AND DEATH <u>11 years</u> <u>1 week</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Terminal Paralytic Disease</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>May 1947</u> to <u>Aug 31 1958</u> that I last saw the deceased alive on <u>Aug 30 1958</u> and that death occurred at <u>4:00 A.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>1717 G. STREET Bldg. M.D.</u>						DATE SIGNED <u>9/1/58</u>	
ACTUAL SIGNATURE <u>W. McKenree Boyer</u>				PHYSICIAN'S NAME (Type) <u>M. McKenree Boyer, M.D., Damascus, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>Sept. 2, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Boys Presbyterian</u>		22d. LOCATION (City, town, or county) (State) <u>Boys, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Olin L. Molesworth</u>				ADDRESS <u>Damascus, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 4 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9219 CERTIFICATE OF DEATH

09195

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clarksville</u> <u>15X-2</u>	
c. LENGTH OF STAY IN 1b <u>3 hrs. 6 min.</u>		d. STREET ADDRESS <u>Montgomery County General Hospital</u>	
3. NAME OF DECEASED (Type or print) First <u>Baby Boy</u> Middle <u>Burgess</u> Last <u>Burgess</u>		4. DATE OF DEATH Month <u>August</u> Day <u>8</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/8/58</u>
9. AGE (In years last birthday) yrs <u>3</u>		IF UNDER 1 YEAR <u>3</u> Months Days <u>6</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NB</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>XXXXXXXXXXXXXXXXXXXX</u>		14. MOTHER'S MAIDEN NAME <u>Doris Elizabet Bell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>Hospital Record</u>	
17. INFORMANT <u>Hospital Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Prematurity.</u> DUE TO (c) <u>Lungs Atelectasis.</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/8</u> , 19 <u>58</u> , to <u>8/8</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8/8</u> , 19 <u>58</u> , and that death occurred at <u>6:30 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Linn R. Leal</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>Born at 3:24 A.M. D.O.B. 6:30 AM</u>	
PHYSICIAN'S NAME (Type) <u>L. I. Leal, M.D.</u>		<u>Gaithersburg, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>8/11/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hopkins Chaple</u>		22d. LOCATION (City, town, or county) (State) <u>Highland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F.C. Higinbotham</u>		ADDRESS <u>Ellicott City, Md.</u>	
24a. REC'D BY REGISTRAR <u>AUG 12 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Strauss</u>	

2073 224XV0

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is completely filled in by the funeral director.
page 3 should be detached and used as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9220

CERTIFICATE OF DEATH

Reg. Dist. No.

09196

1. PLACE OF DEATH o COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>MD</u> b COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>2 hours</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>				d STREET ADDRESS <u>4815-WELLINGTON DR</u>			
3. NAME OF DECEASED (Type or print) First <u>AGNES</u> Middle <u>CECILIA</u> Last <u>BUSCHER</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>30</u> Year <u>1958</u>			
5 SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-2-1877</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>28</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>			
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John N. Mattane</u>				14. MOTHER'S MAIDEN NAME <u>Agnes Doyle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>MR Robt. E. Buscher</u>				Address <u>4815-Wellington Dr</u> <u>Bethesda, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EMBOLISM</u>							
DUE TO (b) <u>CEPHALIC VEIN THROMBOSIS</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>HEART DISEASE</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>7:45 PM 8/30/58</u> to <u>8:30 PM 8/30/58</u> , that I last saw the deceased alive on <u>8/30</u> , 19 <u>58</u> , and that death occurred at <u>12:05 AM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>4890 Battery La. Bethesda, Md.</u> DATE SIGNED <u>8/30/58</u>							
ACTUAL SIGNATURE <u>Charles J. Savarese, Jr.</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Charles J. Savarese, Jr.</u> <u>4890 Battery Lane, Bethesda, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/2/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>SEP 2 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician or completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 10/57

SALARY STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9221

Item 4 Filed 1958-9-2-51 at

CERTIFICATE OF DEATH

09197

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barnesville, Md.</u> c. LENGTH OF STAY IN 1b <u>2 yrs</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dickerson, Md</u> d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ethel Mae Butler</u>			4. DATE OF DEATH Month Day Year <u>August 29, 19 58</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 7-1906</u>		9. AGE (In years last birthday) <u>52</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	12. CITIZEN OF WHAT COUNTRY <u>U S</u>
13. FATHER'S NAME <u>Leon Saunders</u>			14. MOTHER'S MAIDEN NAME <u>Hattie Houser</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT Address <u>H. J. Butler, Barnesville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> 420. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>					INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u> <u>10 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>October 1956</u> to <u>29 Aug. 1958</u> , that I last saw the deceased alive on <u>29 Aug. 1958</u> , and that death occurred at <u>7:40 P. M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>John M. Smith</u>		ADDRESS (Street, city or town, state) <u>Barnesville, Md.</u>		DATE SIGNED <u>29 Aug 58</u>	
PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Aug 31-58</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Manassas</u>	
22d. LOCATION (City, town, or county) (State) <u>Manassas Virginia</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Hillon</u>		ADDRESS <u>Barnesville, Md.</u>		24a. REC'D BY REGISTRAR <u>SEP 2 58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION



9222

CERTIFICATE OF DEATH

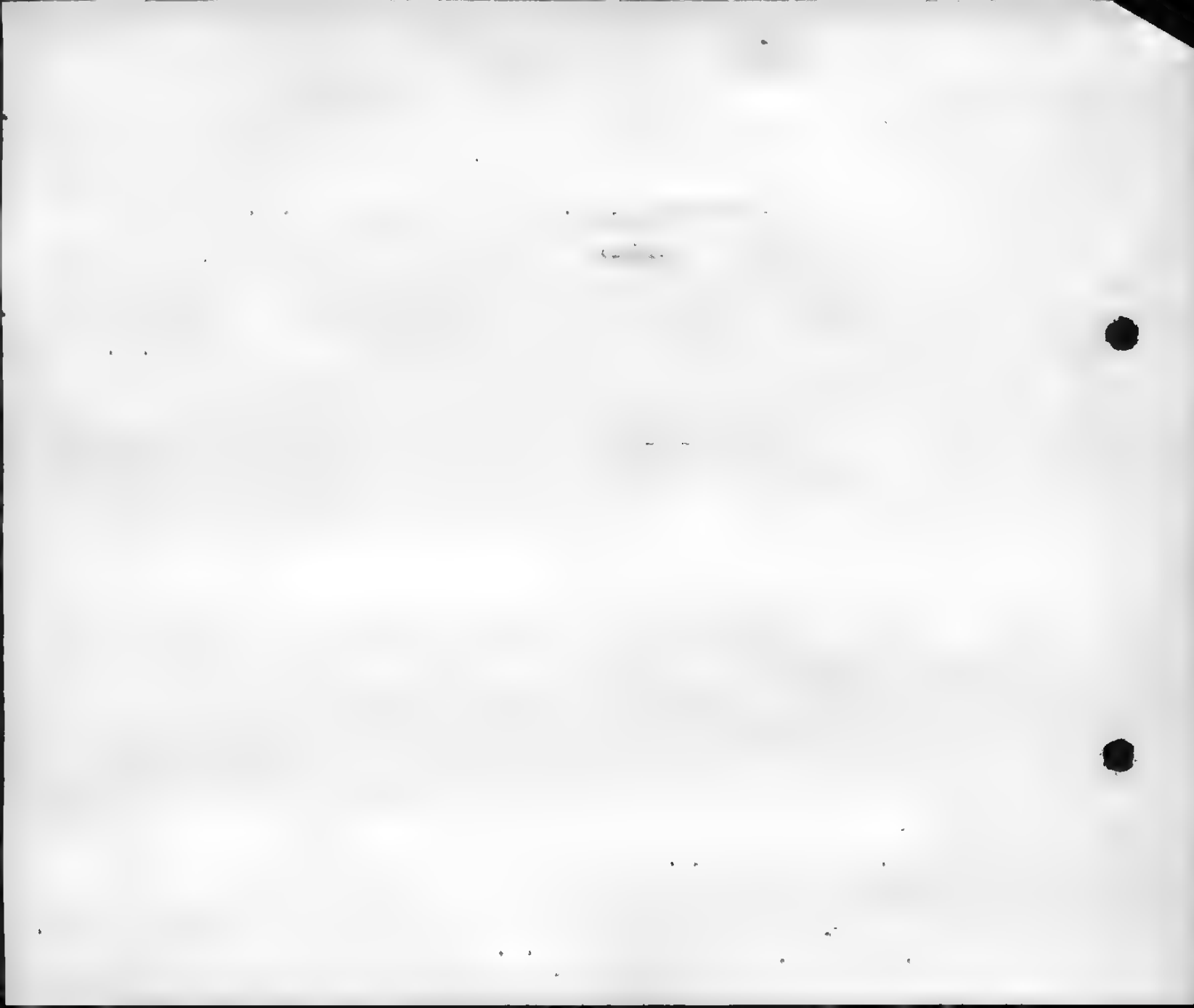
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 123 days		2. USUAL RESIDENCE (Where deceased lived. If institution on: Residence before admission) a. STATE District of Columbia b. COUNTY Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. STREET ADDRESS 1707 Columbia Road, N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Antoinette Middle Irene Last Camarinos		4. DATE OF DEATH Month August Day 30, Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 19, 1910	9. AGE (In years last birthday) 47 yrs.	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Clerk		10b. KIND OF BUSINESS OR INDUSTRY Leather Goods		11. BIRTHPLACE (State or foreign country) Pennsylvania	
13. FATHER'S NAME Emanuel Camarinos		14. MOTHER'S MAIDEN NAME Bessie Vrettas		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-24-2743		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MULTIPLE MYELOMA 203X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 4 YRS.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Prince Georges County, Md.	(State)
21. I certify that I attended the deceased from April 29, 1958 to August 30, 1958 , that I last saw the deceased alive on August 30, 1958 , and that death occurred at 9:03 P.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>G. Richard Lee</i>		M.D. The Clinical Center		DATE SIGNED 8/31/58	
PHYSICIAN'S NAME (Type) G. RICHARD LEE, M.D.		The National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/2/1958	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.		ADDRESS 2901 14th St., N.W. Washington, D.C.		24a. REC'D BY REGISTRAR SEP 3 '58	24b. REGISTRAR'S SIGNATURE <i>Orlando S. Hines</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician on the reverse, Pages 1 and 2 should be filled with the page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy, and in any event within 72 hours after death. the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9223

CERTIFICATE OF DEATH

09199

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> 2 hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cabin John</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Salomon Hospital</u>		d. STREET ADDRESS <u>6532-79th Place</u>	
3. NAME OF DECEASED (Type or print) <u>Charlotte Camplair</u> First Middle Last		4. DATE OF DEATH Month <u>8</u> Day <u>21</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 8 1890</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Germany</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>H. Mueller</u>		14. MOTHER'S MAIDEN NAME <u>B. Rindermann</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>Yes</u> (If yes, give war or date of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Husband George Camplair</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circulatory Failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Myocardial Infarct</u> (c) <u>Arteriosclerotic Heart Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>21 Aug</u> , 1958, to <u>26 Aug</u> , 1958, that I last saw the deceased alive on <u>21 Aug</u> , 1958, and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>William H Killay</u> M.D.		5723 BRYANLEY BLVD	
PHYSICIAN'S NAME (Type) <u>William Henry Killay</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>8/23/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>AUG 25 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9224

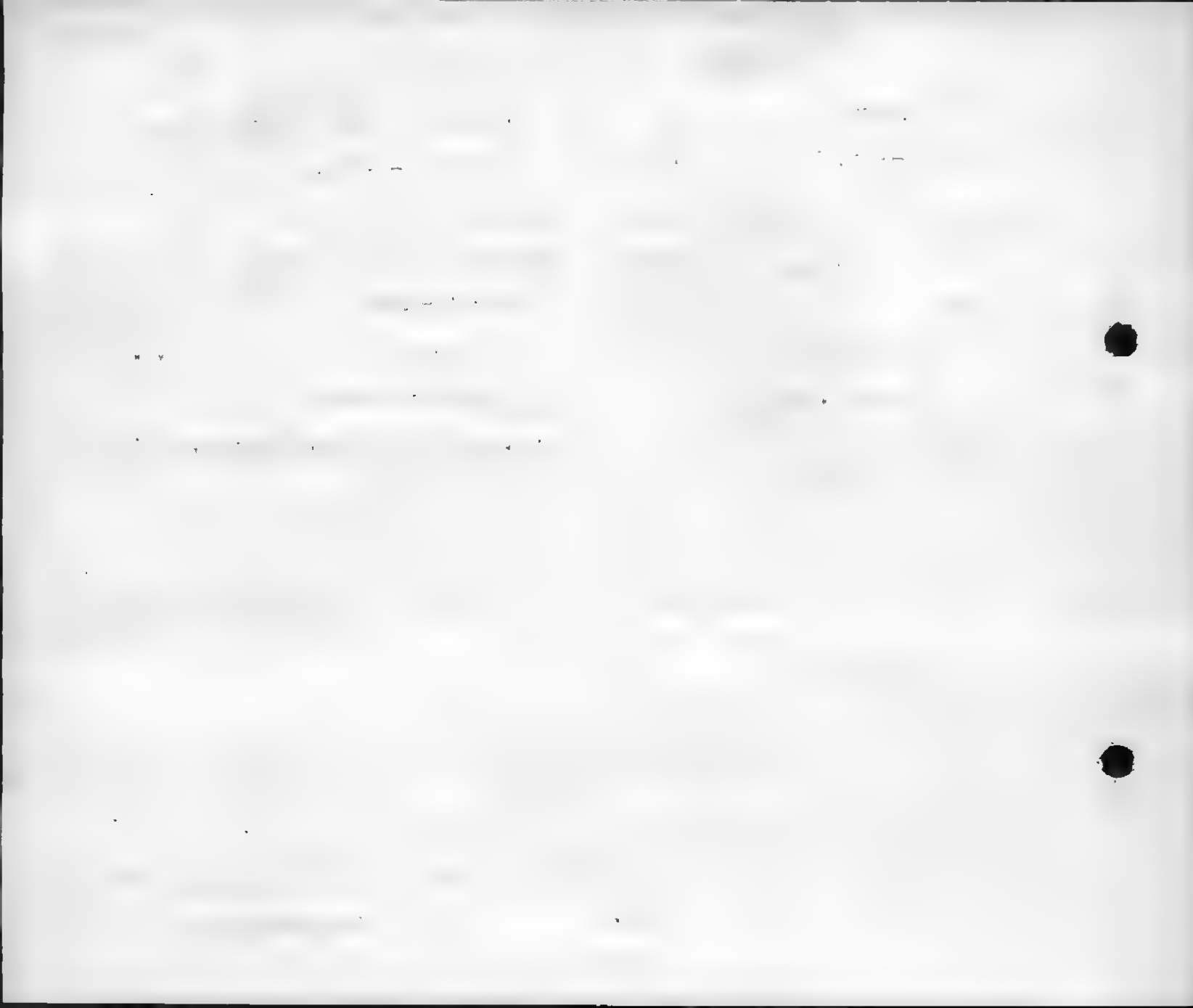
CERTIFICATE OF DEATH

09200

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dickerson—Rural c. LENGTH OF STAY IN 1b 78 yrs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dickerson—Rural d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lucy Middle Lavina Last Carlisle		4. DATE OF DEATH Month August Day 2 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 28-1880
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Own housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Richard C. Carlisle		14. MOTHER'S MAIDEN NAME Francis Appleby	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO (If yes, give war or dates of service)	
17. INFORMANT Mr J. Maurice Carlisle, Dickerson, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion, Acute DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Coronary Arteriosclerosis with Angina DUE TO (c) Hypertensive-Arteriosclerotic Cardiovascular Dis.		INTERVAL BETWEEN ONSET AND DEATH 15 minutes 3 years 13 years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3 May , 19 57 , to 2 Aug , 19 58 , that I last saw the deceased alive on 2 August , 19 58 , and that death occurred at 6:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Barnesville, Md DATE SIGNED 3 Aug 58			
ACTUAL SIGNATURE Gordon M. Smith		PHYSICIAN'S NAME (Type) Gordon M. Smith, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 5-1958	
22c. NAME OF CEMETERY OR CREMATORY Monocacy		22d. LOCATION (City, town, or county) (State) Boodleyville, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Constance C. Hilton		24. REC'D BY REGISTRAR W. J. Leach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9225

CERTIFICATE OF DEATH

Reg. Dist. No. 09201

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 9 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville 2			
d. STREET ADDRESS 100 W. Montgomery Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle J Last Casey				4. DATE OF DEATH Month August Day 16 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 12, 1879	
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cordmaker at's Elevator				10b. KIND OF BUSINESS OR INDUSTRY Connecticut			
13. FATHER'S NAME John J. Casey				14. MOTHER'S MAIDEN NAME Mary Ellen O'Connor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) NO				16. SOCIAL SECURITY NO. YES			
17. INFORMANT Wife				Address Hospital Record Mrs Mary E. Casey			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Adrenal Insufficiency - Shock 150X DUE TO Postoperative Status Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of the Esophagus (c) 6 mos? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 8-8 , 19 58 , to 8-16 , 19 58 , that I last saw the deceased alive on 8-16 , 19 58 , and that death occurred at 5:40 AM, from the causes and on the date stated above.							
ADDRESS (Street, city, or town, state) 1150 Conn. Ave. N.W.				DATE SIGNED 8-16-58			
ACTUAL SIGNATURE J. Winthrop Peabody Jr.				M.D. Wash., D.C.			
PHYSICIAN'S NAME (Type) J. Winthrop Peabody							
22a. BURIAL, CREMATION, REMOVAL (Specify) SHIP RR		22b. DATE THEREOF 8-17-58		22c. NAME OF CEMETERY OR CREMATORY ST-JOHN'S CEMETERY		22d. LOCATION (City, town, or county) (State) NORWALK, CONN	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. CHAMBERS, Jr.				ADDRESS 1400 Chapin St N.W.		24a. REC'D BY REGISTRAR 2 AUG 19 58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Howard			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is completely filled in by the funeral director. Page 3 should be detached and used as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9226

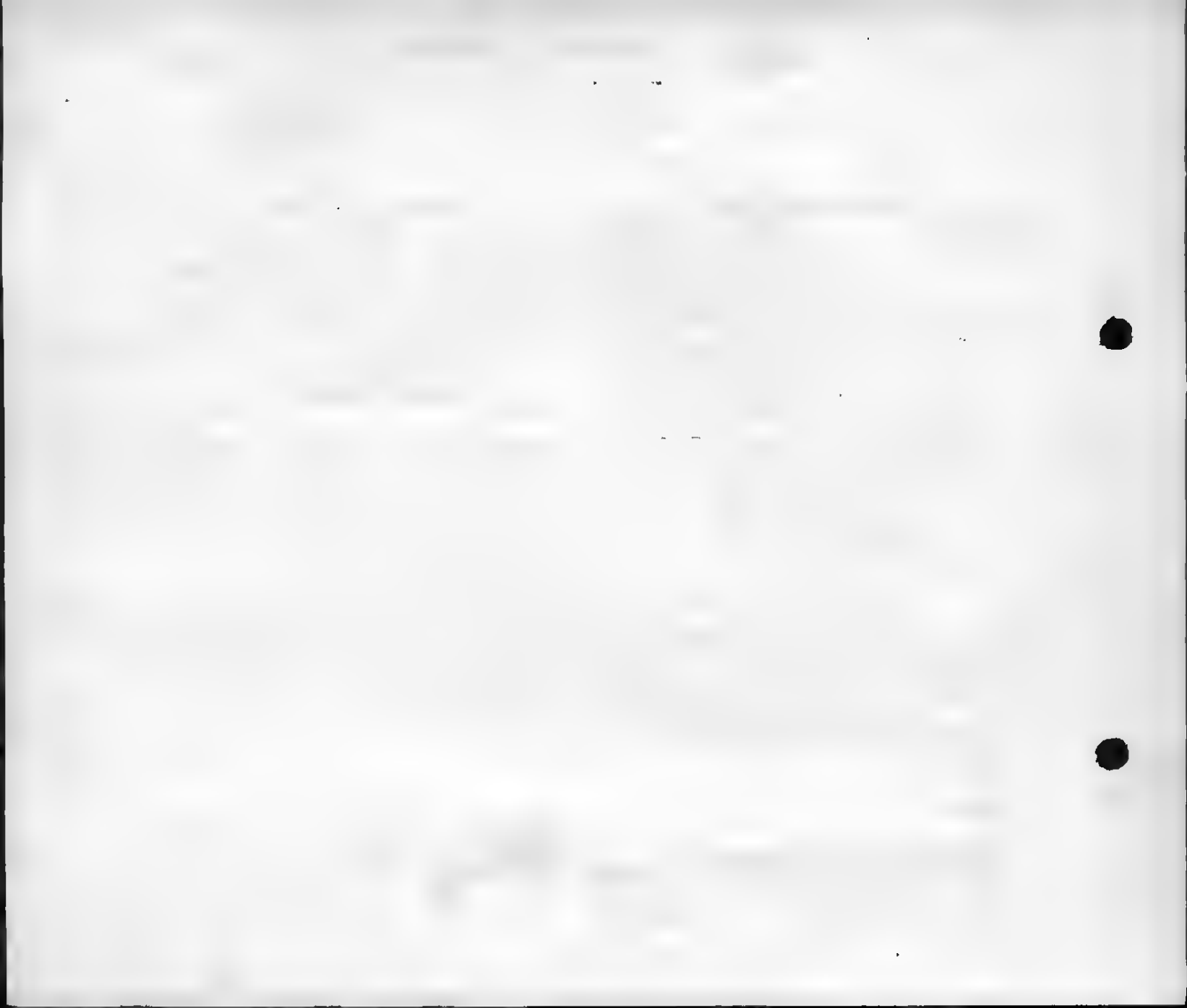
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 14 hrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
				d. STREET ADDRESS 3801 Conn. Ave. N.W.			
3. NAME OF DECEASED (Type or print) First Grace Middle Lenore Last Caulfield				4. DATE OF DEATH Month August Day 20 Year 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/17/86	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months 7 Days 3 Hours Min. 	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Insurance		11. BIRTHPLACE (State or foreign country) Iowa	
13. FATHER'S NAME William R. Nelson				14. MOTHER'S MAIDEN NAME Anne F. Hicks			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO 561-09-9251		17. INFORMANT Henry P. Caulfield Jr.	
				Address 8625 31 st St. NW.		Washington, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TOXEMIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Septicemia DUE TO (c) Carcinoma of Pancreas with Metastases							INTERVAL BETWEEN ONSET AND DEATH 1 day 1 day Unknown
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. 19 p. m. 				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Nov. 15 , 19 52 , to Aug 20 , 19 58 , that I last saw the deceased alive on Aug 20 , 19 58 , and that death occurred at 12:35 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE John H. Tuohy				ADDRESS (Street, city or town, state) 7720 Wisc. Ave. Bethesda, Md.			
PHYSICIAN'S NAME (Type) John H. Tuohy				DATE SIGNED 8/20/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/25/58		22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		22d. LOCATION (City, town, or county) (State) Silver Spring, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE AUG 25 '58	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon 2 and 3 and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9227

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09203

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH

a. COUNTY

Montgomery

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Olney

c. LENGTH OF STAY IN 1b

2 1/2 days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Montgomery County General Hospital

2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission)

a. STATE

Maryland

b. COUNTY

Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Olney

STREET ADDRESS

* IS RESIDENCE
ON A FARM?YES ☐ NO ☒3. NAME OF
DECEASED
(Type or print)

First

Joseph

Middle

Charles

Last

Chase

4. DATE
OF
DEATH

Month

August

Day

4

Year

19 58

5. SEX

Male

6. COLOR OR RACE

Negro

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

1/5/30

9. AGE (In years
last birthday)

28 yrs

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS

Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Truck Driver

10b. KIND OF BUSINESS OR INDUSTRY

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

William Chase

14. MOTHER'S MAIDEN NAME

Katherine Lincoln

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

Yes

Korea

16. SOCIAL SECURITY NO.

577 36 5124

17. INFORMANT

Hospital Record

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Respiratory Failure

INTERVAL BETWEEN
ONSET AND DEATH

12 hrs.

16x DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b) Fracture of Skull (Basil)

2 1/2 days

DUE TO

(c) Crushed Chest

2 1/2 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

Fracture of Left Arm, Numerous Contusions and Lacerations of head and

19. WAS AUTOPSY
PERFORMED?YES ☐ NO ☒20a. EXTERNAL CAUSE WAS
PRIMARY ☒ OR CONTRIBUTING ☐
CAUSE OF DEATH.20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
Driver of car involved in head-on collision.

face.

20c. TIME OF INJURY

Month, Day, Year

Hour a. m.

7:00

8/2 19 58

20d. INJURY OCCURRED

While at work ☐ Not while at work ☒20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

Maryland Rt. #108 nr. Etchison

20f. (City or town)

Montg.

(County)

Md.

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

Frank J. Broschart

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

8/4/58

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

Aug. 6

22c. NAME OF CEMETERY OR CREMATORY

Arlington Nat.

22d. LOCATION (City, town, or county)

Arlington

(State)

Virginia

23. FUNERAL DIRECTOR'S SIGNATURE

Roy W. Barber

ADDRESS

Laytonsville, Md.

24a. REC'D BY REGISTRAR

AUG 6 '58

24b. REGISTRAR'S SIGNATURE

D. W. Smith

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 1, 2 and 3 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2 and 3 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9228

CERTIFICATE OF DEATH

09204

Reg. Dist. No.

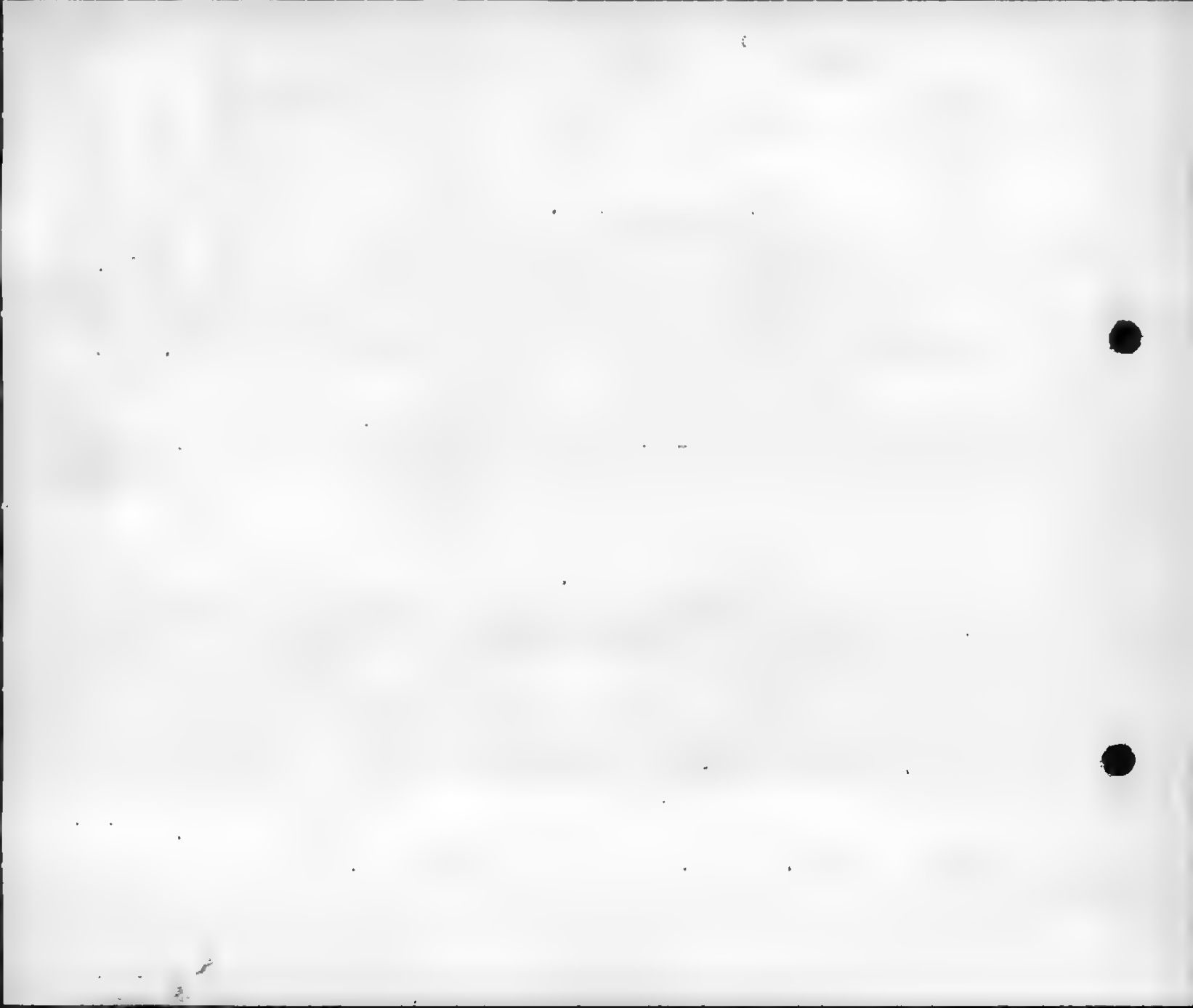
1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 36 days		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Virginia		b. COUNTY Fairfax		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Falls Church		d. STREET ADDRESS 1117 Rolfs Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Martha		Middle Susan		Last Christopher		4. DATE OF DEATH Month August		Day 30,		Year 1958		5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 6, 1914		9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR Months 44		IF UNDER 24 HRS Days 44		Hours 44		Min. 44		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary	
10b. KIND OF BUSINESS OR INDUSTRY Unascertainable		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Alonzo Easley		14. MOTHER'S MAIDEN NAME Kate Ragsdale		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 227-05-8442		17. INFORMANT The Medical Record	
17. ADDRESS The Clinical Center, Bethesda 14, Maryland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Breast with Carcinomatosis DUE TO Hemopericardium and hydrothorax DUE TO Neoplastic involvement of Pleura Epicardium PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma involving both Adrenals, Thyroid and Dura		INTERVAL BETWEEN ONSET AND DEATH 3 years weeks weeks		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Bethesda		20g. (County) Montgomery		20h. (State) Md.		21. I certify that I attended the deceased from July 25, 1958 , to August 30, 1958 , that I last saw the deceased alive on August 30, 1958 , and that death occurred at 12:15 A.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) The Clinical Center		DATE SIGNED 8/30/58		ACTUAL SIGNATURE Richard H. Moy		M.D. RICHARD H. MOY, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 3-1958		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) Arlington		22e. (State) Va.		23. FUNERAL DIRECTOR'S SIGNATURE Chris F. Jones		23a. REC'D BY REGISTRAR SEP 2 '58		23b. REGISTRAR'S SIGNATURE Arthur S. Frank	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician on the death certificate. This certificate has been signed by the attending physician on the death certificate. This certificate has been signed by the attending physician on the death certificate.

page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9229

CERTIFICATE OF DEATH

09205

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barnesville		c. LENGTH OF STAY IN 1b 85 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS Barnesville	
		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) Edmonia		4. DATE OF DEATH Month August Day 21 Year 19 58	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 15-1858
9. AGE (In years last birthday) 100 yrs.		10. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S	

13. FATHER'S NAME John Amish		14. MOTHER'S MAIDEN NAME Bettie Watson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Miss Beatie Clagatt, Barnesville, Md		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Bronchial Pneumonia		4 days
DUE TO (b) Malnutrition		6 months
DUE TO (c) Extreme Arteriosclerosis Generalized		10 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. I certify that I attended the deceased from June 1956 to 21 Aug. 1958 , that I last saw the deceased alive on 20 Aug. 1958 , and that death occurred at 3:10 P.M. from the causes and on the date stated above.		DATE SIGNED 22 Aug 58
ACTUAL SIGNATURE Gordon M. Smith M.D.		ADDRESS (Street, city or town, state) Barnesville, Md.
PHYSICIAN'S NAME (Type) Gordon M. Smith, M.D.		

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 25-1958	22c. NAME OF CEMETERY OR CREMATORY St Marys	22d. LOCATION (City, town, or county) (State) Barnesville, Md
23. FUNERAL DIRECTOR'S SIGNATURE Constance C. Hilton		24a. REC'D BY REGISTRAR Aug 26 '58	24b. REGISTRAR'S SIGNATURE Arthur L. Hearn

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



CERTIFICATE OF DEATH

Reg. Dist. No. 215

9230

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 21 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington ✓	
f. STREET ADDRESS 717 Atlantic Street, S.E.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Francis Xavier CLARK		4. DATE OF DEATH Month Day Year August 16 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27 July 1958
9. AGE (In years last birthday) yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Paul Joseph CLARK		14. MOTHER'S MAIDEN NAME Alice HOGDON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (Father) Paul J. CLARK (Same As #2)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Primary Atherosclerosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prematurity</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 19 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 27 July 1958, to 16 August 1958, that I last saw the deceased alive on 16 August 1958, and that death occurred at 5:45 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David Harris</u>		DATE SIGNED 8-18-58	
PHYSICIAN'S NAME (Type) David Harris, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-19-58	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Jr.</u>		ADDRESS W.W. Chambers, 1400 Chapin St., N.W. Washington, D.C.	
24a. REC'D BY REGISTRAR DATE AUG 20 '58		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9231

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 6 Form 9233 9-3-51 et

Reg. Dist. No.

FOR STATE
HEALTH-DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park	
c. LENGTH OF STAY IN 1b 2 hrs.		d. STREET ADDRESS 7700 Blair Rd.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery County General		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James Edward Clemons		4. DATE OF DEATH Month Aug. Day 23 , Year 1958	
5. SEX male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/15/1930
9. AGE (In years last birthday) 28 yrs		IF UNDER 1 YEAR Months 28 Days 19	IF UNDER 24 HRS. Hours 19 Min 19
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Haywood Clemons		14. MOTHER'S MAIDEN NAME Mary Chase	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage, Cerebral			
823X DUE TO (b) Fracture of Skull			
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) Auto accident			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of auto that failed to make curve	
20c. TIME OF INJURY Month, Day, Year 1:23 a.m. 8/23/58	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) Md. R-115	20f. (City or town) (County) (State) nr Rockville Montg. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Frank J. Broschart</i>		DATE SIGNED 8/23/58	
EXAMINER'S NAME (Type) Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/26/58	22c. NAME OF CEMETERY OR CREMATORY Oak Grove.,	22d. LOCATION (City, town, or county) (State) Mt. Zion, Md.
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Snowden</i>		ADDRESS Rockville, Md.	
24a. REC'D BY REGISTRAR DATE AUG 28 '58		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMG-1. This form may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

09208

Reg. Dist. No.

9180

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) STRATTONVILLE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 901 MAPLEWOOD AVENUE		d. STREET ADDRESS MAIN STREET	
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE HARRISON CRISPIN		4. DATE OF DEATH Month Day Year AUGUST 26 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 15, 1868
9. AGE (In years last birthday) yrs. 89		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LUMBERMAN		10b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED LUMBER	
11. BIRTHPLACE (State or foreign country) CLARION COUNTY, PA.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME WILLIAM CRISPIN		14. MOTHER'S MAIDEN NAME UNKNOWN GORDON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT GEORGE H. REED, MAIN ST., STRATTONVILLE, PA.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1 day (c) 4 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 2, 1953 , to Aug 26, 1958 , that I last saw the deceased alive on Aug 26, 1958 , and that death occurred at 4 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE H. B. Orleans		ADDRESS (Street, city or town, state) DATE SIGNED 9500 Colverville Rd Silver Spring Md	
PHYSICIAN'S NAME (Type) H. B. ORLEANS			
22a. BURIAL, CREMATION, REMOVAL (Specify) ENTOMBMENT	22b. DATE THEREOF AUG. 30, 1958	22c. NAME OF CEMETERY OR CREMATORY STRATTONVILLE CEMETERY	22d. LOCATION (City, town, or county) (State) STRATTONVILLE, PA.
23. FUNERAL DIRECTOR'S SIGNATURE Walter E. Rumpelberg		24a. REC'D BY REGISTRAR DATE AUG 28 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The form requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician or completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 1 and 2 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-form if permit. File pages 1 and 2 with the State Board of Health, or its designated agent, for a burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9232 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09209

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY P. G.	
b. CITY OR TOWN (If outside corporate limits, write RURAL) Near Etchison		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Md-R-108		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel	
3. NAME OF DECEASED (Type or print) Dallas First Levi Middle Cross Last		4. DATE OF DEATH Aug. 2, 1958 Month 2 Day 19 Year	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6/30/28
9. AGE (in years last birthday) 30 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lloyd Cross		14. MOTHER'S MAIDEN NAME Ella Batterial	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. Lloyd Cross - Highland Md	
17. INFORMANT Lloyd Cross - Highland Md		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hemorrhage 316X DUE TO (b) Fracture of skull (Basal) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) middle	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Driver of car involved in head on collision	
20c. TIME OF INJURY Month, Day, Year 7:00 a.m. 8/2/58 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) Md.R 108		20f. (City or town) (County) (State) Etchison Montg. u.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart M D		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Aug. 2, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried Aug 4, 1958		22b. DATE THEREOF Aug 4, 1958	
22c. NAME OF CEMETERY OR CREMATORY Providence Cem		22d. LOCATION (City, town, or county) (State) Glen Elg Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Caldwell		24a. REC'D BY REGISTRAR AUG 5 '58	
ADDRESS Laurel, Md		24b. REGISTRAR'S SIGNATURE W. W. Caldwell	



9181

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON DC			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON DC			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 708 PHILADELPHIA AVE.				d. STREET ADDRESS 1415 Geranium Street IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MABEL First H Middle DARTE Last				4. DATE OF DEATH AUG Month 1 Day 19 Year 58			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 8, 1873	
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) CALIFORNIA		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME JOHN W. HEMENWAY				14. MOTHER'S MAIDEN NAME NANCY CANNIFF			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT AMY D. CRIPPEN Address 1415 GERANIUM NW			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decomposition 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Hemorrhage 7/26/58							INTERVAL BETWEEN ONSET AND DEATH 3-4 yrs 2
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb 1957, to Aug 1958, that I last saw the deceased alive on 30 July 1958, and that death occurred at 11 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE William D. Aud M.D.				ADDRESS (Street, city or town, state) 9126 Cokesville Rd		DATE SIGNED 8/1/58	
PHYSICIAN'S NAME (Type) William D. Aud				Silver Spring Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 8/4/58		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory		22d. LOCATION (City, town, or county) (State) Prince Georges Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.				ADDRESS Washington D.C.		24a. REC'D BY REGISTRAR Aug 4 '58	
				24b. REGISTRAR'S SIGNATURE W. Beach			

TO HOSPITAL ■■■ ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9233

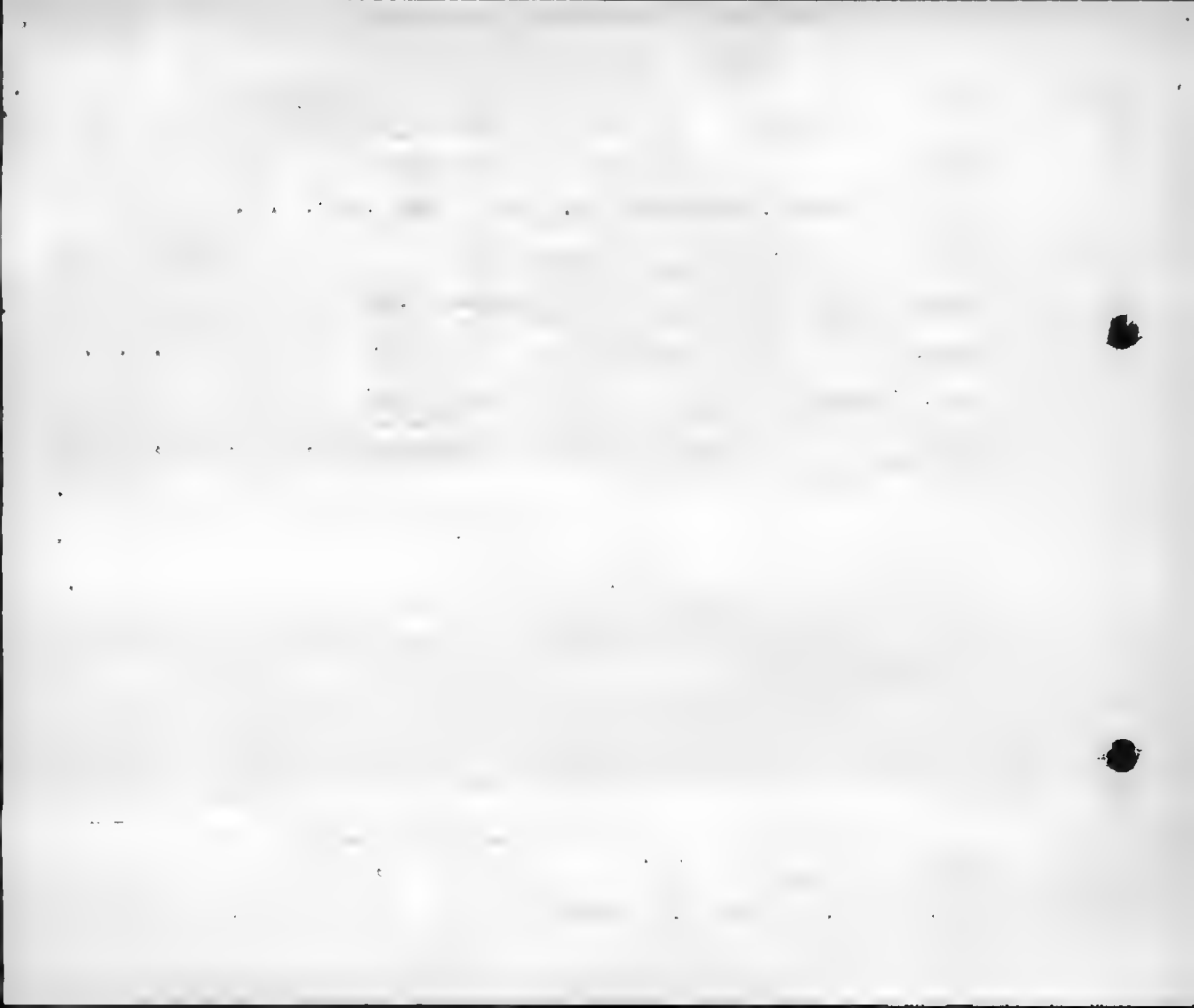
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 96 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 7729 16th Street, N. W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edith Middle Esther Last Davis		4. DATE OF DEATH Month August Day 3 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 1, 1917
9. AGE (In years last birthday) 41 yrs.		10. IF UNDER 1 YEAR Months 41 Days 11 Hours 11 Min 11	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		12. KIND OF BUSINESS OR INDUSTRY Public Schools	
13. BIRTHPLACE (State or foreign country) New York		14. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. FATHER'S NAME Nathan Bitterman		16. MOTHER'S MAIDEN NAME Mollie Tzweig	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No		18. SOCIAL SECURITY NO. Unascertainable	
19. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Gastrointestinal bleeding DUE TO (c) Reticulum cell sarcoma		INTERVAL BETWEEN ONSET AND DEATH 12 hrs. 36 hrs. 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 29, 1958 to August 3, 1958 that I last saw the deceased alive on August 3, 1958 and that death occurred at 7:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland DATE SIGNED 8-3-58			
ACTUAL SIGNATURE Leonard Garren, M. D.		PHYSICIAN'S NAME (Type) Leonard Garren, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 4, 1958	
22c. NAME OF CEMETERY OR CREMATORY Elesavetgrad Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Danzansky & Sons - 3501 14th St., NW.		24a. REC'D BY REGISTRAR AUG 5 '58	
24b. REGISTRAR'S SIGNATURE W. H. Smith			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9234

CERTIFICATE OF DEATH

09212

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN TB <u>10 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Kensington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>3910 Hampden ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Rosie</u> Middle <u>Virginia</u> Last <u>Davis</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>15</u> Year <u>1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 8, 1910</u>		9. AGE (In years last birthday) <u>48</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles H. Davis</u>				14. MOTHER'S MAIDEN NAME <u>Smathers (CARRIE)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) [If yes, give war or dates of service]				16. SOCIAL SECURITY NO. <u>214-324187</u>			
				17. INFORMANT <u>John H. Kelley, 4209 Plym. Mill Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> DUE TO <u>Generalized Peritonitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Cervix</u> (c) <u>-</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-7-58</u> to <u>8-18-58</u> , that I last saw the deceased alive on <u>8-17-58</u> , 19 <u>58</u> , and that death occurred at <u>8:15 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>921-20 48th NW Wash. 6 Dc.</u> DATE SIGNED							
ACTUAL SIGNATURE <u>Robert L. Suorden</u> M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REINTERMENT (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>8/22/58</u>		<u>Ash Memorial.</u>		<u>Sandy Spring, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Suorden</u>				ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 21 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur J. Hines</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician on page 3 should be delivered for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9235

CERTIFICATE OF DEATH

09213

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>32 days</u>		d. STREET ADDRESS <u>101 WILLIAMSBURG DR</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>G</u> Last <u>DAWSON</u>		4. DATE OF DEATH Month <u>August</u> Day <u>4</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-14-04</u>
9. AGE (In years lost birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ass't. Mgr. - Mens Clothing Dept. Hecht Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WASH D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Dawson</u>		14. MOTHER'S MAIDEN NAME <u>MARY ANN HOUCK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>578-10-3797</u>	
17. INFORMANT <u>Mrs. Ethel S. Dawson, 101 Williamsburg Drive Silver Spring, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> 454.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchogenic Carcinoma (left lung) - Thrombophlebitis (leg)</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>1958</u> Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/13</u> , 19 <u>58</u> , to <u>8/14</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8/13</u> , 19 <u>58</u> , and that death occurred at <u>9:54 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William D. Aud</u> M.D.		ADDRESS (Street, city or town, state) <u>9056 Silverville Rd Silver Spring, Md.</u> DATE SIGNED <u>8/14/58</u>	
PHYSICIAN'S NAME (Type) <u>WILLIAM D. AUD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>8/7/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>GLENWOOD CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u> ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>AUG 7 '58</u>	24b. REGISTRAR'S SIGNATURE <u> </u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

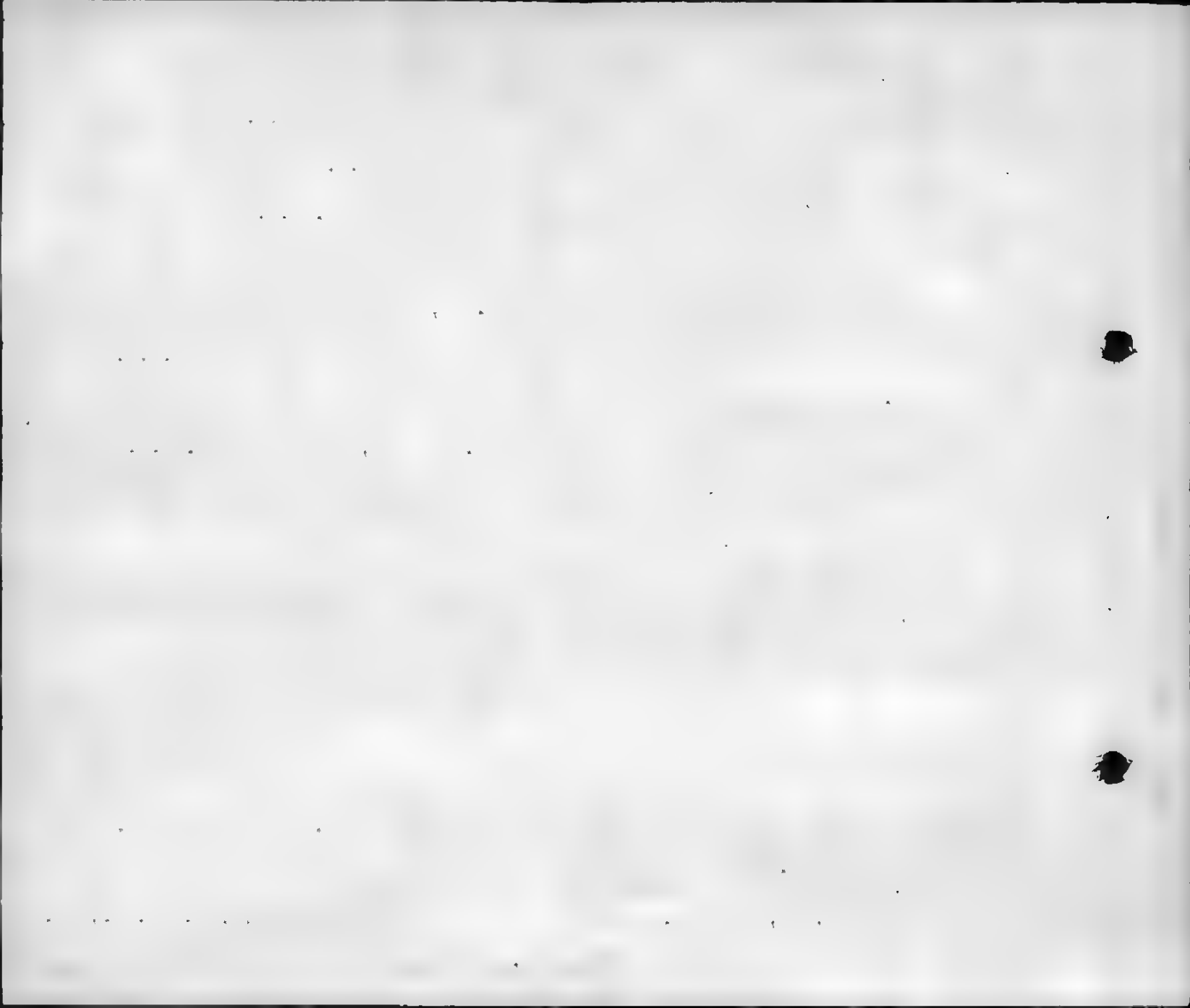
9182

CERTIFICATE OF DEATH

Reg. Dist. No.

Assist Medical Examiner notified and will approve
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY in 1b <u>8 years</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ralls Nursing Home</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Washington D.C.</u> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u> d. STREET ADDRESS <u>1332 Locust Rd., N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MABEL</u> First Middle Last 4. DATE OF DEATH <u>August 20 1958</u> Month Day Year				5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Sept. 25, 1878</u> 9. AGE (In years last birthday) <u>83</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> 11. BIRTHPLACE (State or foreign country) <u>New York</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Jacob H. Kirkpatrick</u> 14. MOTHER'S MAIDEN NAME <u>Sarah Frances Swinnerton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <u>none</u> 17. INFORMANT <u>Robert H. Denton</u> Address <u>1332 Locust Rd., N.W. Washington D.C.</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>Cardio-renal-Vascular Athroclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Second</u> DUE TO (b) <u>Sept.</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Abdominal distension</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>7/13</u> , 19 <u>58</u> , to <u>7/18</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>7/18</u> , 19 <u>58</u> , and that death occurred at <u>4 AM</u> , from the causes and on the date stated above. <u>8/20/58</u> ADDRESS (Street, city or town, state) <u>7600 Carroll Ave., Takoma Park, Md.</u> DATE SIGNED <u>8/20/58</u>							
ACTUAL SIGNATURE <u>Raymond O. West</u> M.D. <u>7600 Carroll Ave., Takoma Park, Md.</u>				PHYSICIAN'S NAME (Type) <u>Raymond O. West</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Aug. 22, 1958</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>				22d. LOCATION (City, town, or county) (State) <u>Pr. Geo. Co., Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Silver Spring, Md.</u>				24a. REC'D BY REGISTRAR <u>[Signature]</u> DATE <u>Aug 22 '58</u>			
24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>							



9236

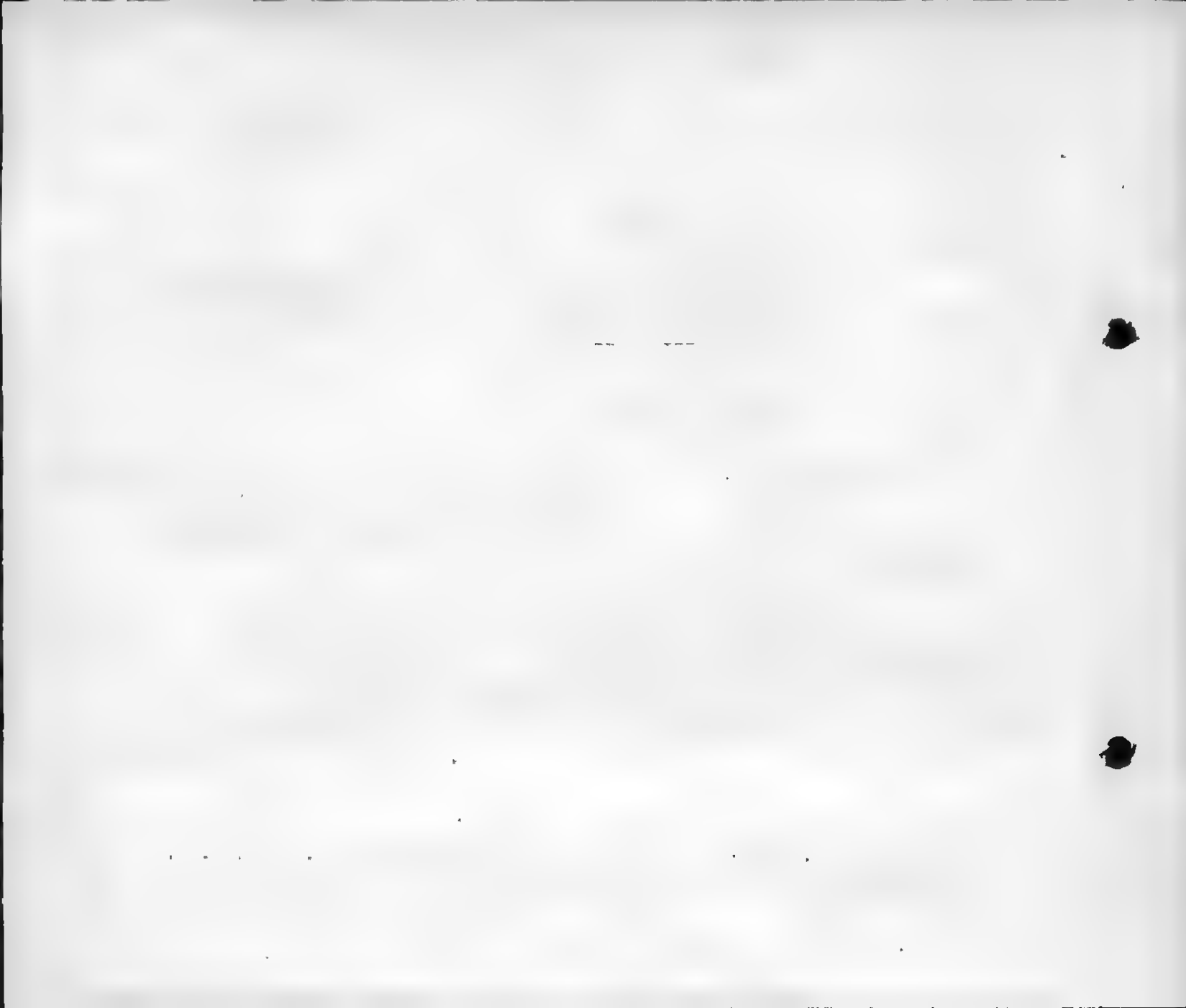
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cabin John</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. STREET ADDRESS <u>3333 Arthur Blvd.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jessie R. Dickinson</u>				4. DATE OF DEATH Month Day Year <u>Aug. 10 1958</u>			
5. SEX <u>f</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 17, 1874</u>		9. AGE (In years last birthday) <u>83</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Month Days Hours Min. <u>10 23</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (State or foreign country) <u>Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>Canada</u>	
13. FATHER'S NAME <u>Wesley Mason</u>				14. MOTHER'S MAIDEN NAME <u>Clara Blois</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>L. R. Dickinson</u> Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic Cardiovascular disease</u> DUE TO (c) <u>-----</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 1/2 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 15</u> to <u>Aug 10</u> , 19 <u>58</u> ; that I last saw the deceased alive on <u>Aug 10</u> , 19 <u>58</u> , and that death occurred on <u>Aug 10</u> , 19 <u>58</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Donald A. Ekman</u> M.D.				ADDRESS (Street, city or town, state) <u>5707 Wisconsin Ave.</u> DATE SIGNED <u>8/10/58</u>			
PHYSICIAN'S NAME (Type) <u>Donald A. Ekman</u>				5707 Wisconsin Ave. Wash, D. C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/13/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>AUG 12 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Krueger</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 1 and 2 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9237 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09216

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN TB D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SUBURBAN		e. STREET ADDRESS 11014 Glueck Lane	
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES TERRENCE DONNELLY		4. DATE OF DEATH Month Day Year AUG 6 19 58	
5. SEX MALE 6. COLOR OR RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH FEB. 28 1946		9. AGE (In years last birthday) 12 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) WASH. D.C.		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME CORNELIUS DONNELLY		14. MOTHER'S MAIDEN NAME MYRA Mc CLOSKEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Cornelius Donnelly, father—same as 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL EDEMA AND ANOXIA 525X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ACUTE PULMONARY EDEMA (c) INTERSTITIAL PNEUMONIA, BILATERAL		INTERVAL BETWEEN ONSET AND DEATH hours hours unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion a death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Frank J. Broschert		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/9/58	
22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		22d. LOCATION (City, town, or county) (State) Silver Spring, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		24a. REC'D BY REGISTRAR DATE AUG 11 '58	
		24b. REGISTRAR'S SIGNATURE A. J. Schuch	



CERTIFICATE OF DEATH

09217

Reg. Dist. No.

9238

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 2 hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase			
f. STREET ADDRESS 3711 Taylor Street				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Emma Middle Casey Last Doran				4. DATE OF DEATH Month August Day 23 Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 1, 1861	
9. AGE (In years last birthday) 96		IF UNDER 1 YEAR Months 96 Days 96 Hours 96 Min 96		IF UNDER 24 HRS. Months 96 Days 96 Hours 96 Min 96			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Galveston, Texas				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Thomas Casey				14. MOTHER'S MAIDEN NAME Catherine Fay			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Daughter		Address Miss Helen Fay Doran As above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart failure DUE TO 4 hrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO 3 years (c) Broncho pneumonia DUE TO 4 hrs							INTERVAL BETWEEN ONSET AND DEATH 12 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 441X E.V.A. 48 hrs							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 22, 1958 , to Aug 23, 1958 , that I last saw the deceased alive on Aug 22, 1958 , and that death occurred at 12:30 P.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 10511 Summit Ave Kensington, Md.				DATE SIGNED 8/23/58			
ACTUAL SIGNATURE George Sharpe				M.D. 10511 Summit Ave			
PHYSICIAN'S NAME (Type) George Sharpe							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 26, 1958		22c. NAME OF CEMETERY OR CREMATORY Congressional		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Jim Lee				ADDRESS 300 4th St. N.E. Wash DC		24a. REC'D BY REGISTRAR DATE AUG 27 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is to be filed in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9183

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Palmer Park, Hyattsville Md.</u>	
c. LENGTH OF STAY IN 1b <u>22 1/2 Hrs</u>		d. STREET ADDRESS <u>8350 Allendale Dr.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Harry</u> First <u>Frankis Dwyer</u> Middle <u>Frankis</u> Last		4. DATE OF DEATH <u>8</u> - <u>12</u> - <u>1958</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>8-27-03</u>	9. AGE (in years last birthday) <u>54</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plasterer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DC.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Elmer Dwyer</u>		14. MOTHER'S MAIDEN NAME <u>Annie Loretta May</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>?</u>		17. INFORMANT <u>Hospital Record</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Edema</u> DUE TO <u>Cerebral Contusion</u> DUE TO <u>Fracture of Skull</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fell 25 ft from Scaffold while plastering</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>3:49 P.M. 8-11 1958</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>St Bernard's School Silver Spring MontCo</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschant</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/16/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis Gasch's Sons</u>		24a. REC'D BY REGISTRAR <u>18 '58</u>	
ADDRESS <u>4739 Balto. Ave. Hyattsville, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 1 and 2 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be filed as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09219

9239

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE [Where deceased lived. If institution: Residence before admission] o. STATE District of Columbia COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 1040 Wahler Place, S.E.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lillie Middle Lang Last EARLY		4. DATE OF DEATH Month August Day 28 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 March 1899
9. AGE (In years last birthday) 59 yrs		IF UNDER 1 YEAR: Months Days Hours Min IF UNDER 24 HRS: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Texas		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Angus LANG		14. MOTHER'S MAIDEN NAME Emma LUDWIG	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) Unknown	
17. INFORMANT (Daughter) Mrs. Betty J. Mersereau (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma to Brain 165X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Adenocarcinoma of the Lung DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 16 August, 19 58 to 28 August, 19 58 , that I last saw the deceased alive on 28 August, 19 58 , and that death occurred at 9:25 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Murray G. Mitts		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 8-29-58	
PHYSICIAN'S NAME (Type) Murray G. Mitts, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-2-58	22c. NAME OF CEMETERY OR CREMATORY Washington Nat'l Cemetery	22d. LOCATION (City, town, or county) (State) Suitland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co. 517 11TH ST. SE, WASH. D. C.		24a. REC'D BY REGISTRAR DATE SEP 3 '58	24b. REGISTRAR'S SIGNATURE Robert S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and is hereby certified for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9240

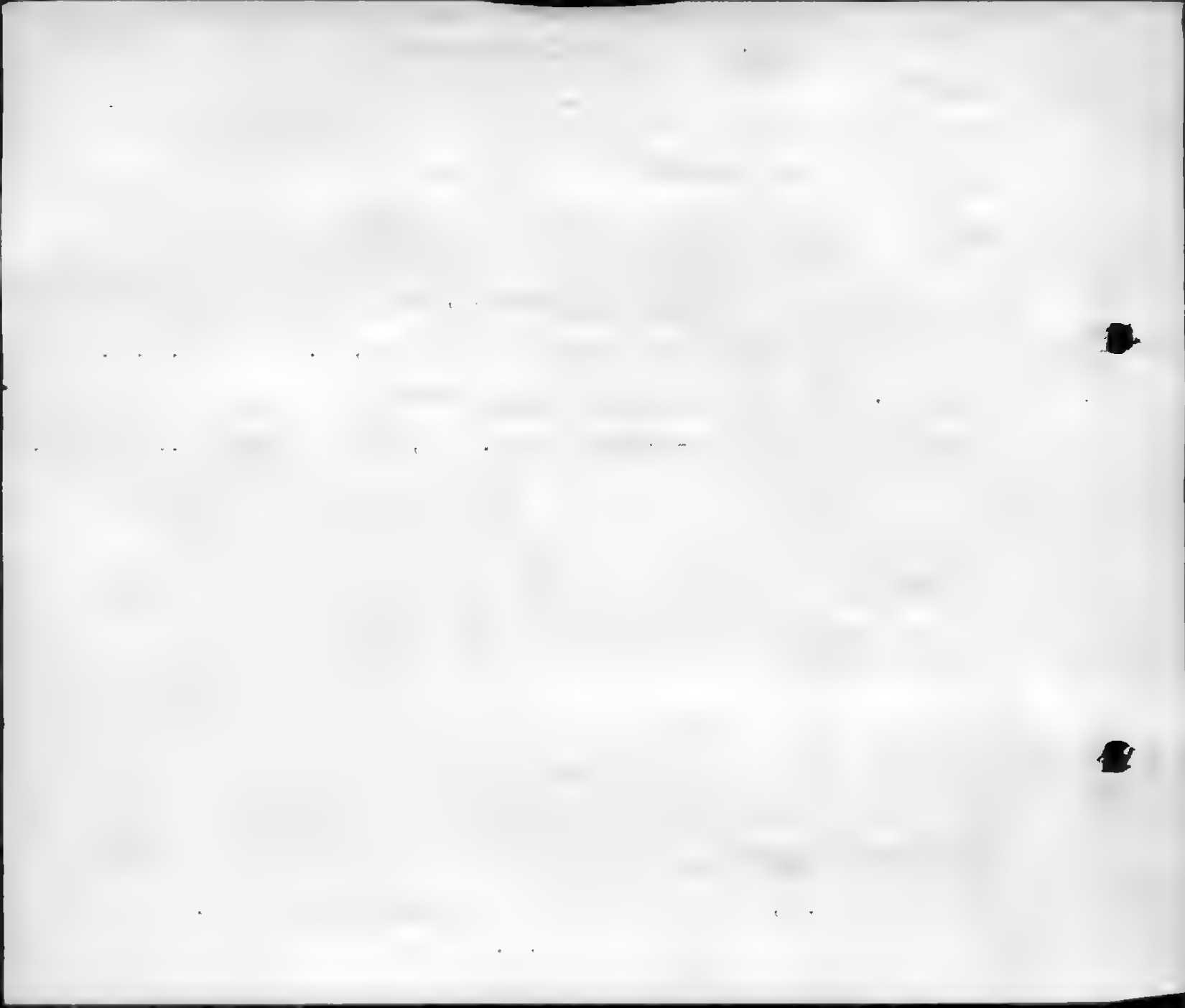
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE M.D. b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 3 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1541 EAST WEST HIGHWAY				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			
f. STREET ADDRESS 1548				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JAMES PATRICK FINN				4. DATE OF DEATH AUGUST 25 1958			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1902 MARCH 17, 1900	
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SERVICE REPRESENTATIVE				10b. KIND OF BUSINESS OR INDUSTRY UNDERWOOD TYPEWRITERS			
11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME MICHAEL J. FINN				14. MOTHER'S MAIDEN NAME ELLA BRANNEN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) YES WW #1 & 2				16. SOCIAL SECURITY NO. 577-09-1325			
17. INFORMANT MARY H. FINN				Address 1548 1541 EAST WEST HWY, SILVER SPR.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LUNG w DUE TO extensive metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from May 12, 1958 , to AUG 25, 1958 , that I last saw the deceased alive on AUG 21, 1958 , and that death occurred at 10:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1025 VERMONT AVE N. W. DATE SIGNED 8/25/58 ACTUAL SIGNATURE Gas. Berkenbilt MD. M.D. 1025 VERMONT AVE N. W. PHYSICIAN'S NAME (Type) JOSEPH BERKENBILT							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF AUG. 28, 1958			
22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY FORT MYER, VA.				22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Walter C. Humphrey				24a. REC'D BY REGISTRAR DATE AUG 27 '58			
24b. REGISTRAR'S SIGNATURE Arthur L. Hanks							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 09221

9184

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Carmody Hills, Md.</u>	
c. LENGTH OF STAY IN 1b <u>5 mi</u>		d. STREET ADDRESS <u>504-73 St. N.E.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>Victor</u> First <u>A.</u> Middle <u>Fowler</u> Last		4. DATE OF DEATH Month <u>8</u> Day <u>4</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>wh</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-17-11</u>
9. AGE (In years last birthday) <u>46</u> yrs.		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>6</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>carpet layer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Benjamin F. Fowler</u>	
14. MOTHER'S MAIDEN NAME <u>Alice Cora Buckmaster</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hosp. Record</u> Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>4</u> (c) <u>1</u> DUE TO Cause lost.		INTERVAL BETWEEN ONSET AND DEATH: <u>1/2 hr</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE <u>Frank J. Broschant</u>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	<u>8-4-58</u>

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-7-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Christ Episcopal Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Port Republic Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sammons Bros Funeral Home</u>		24a. REC'D BY REGISTRAR <u>Wash. DC</u>	24b. REGISTRAR'S SIGNATURE <u>Wash. DC</u>
DATE <u>AUG 5 '58</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be examined within 24 hours after death. If any delay is necessary, please enclose the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician or completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

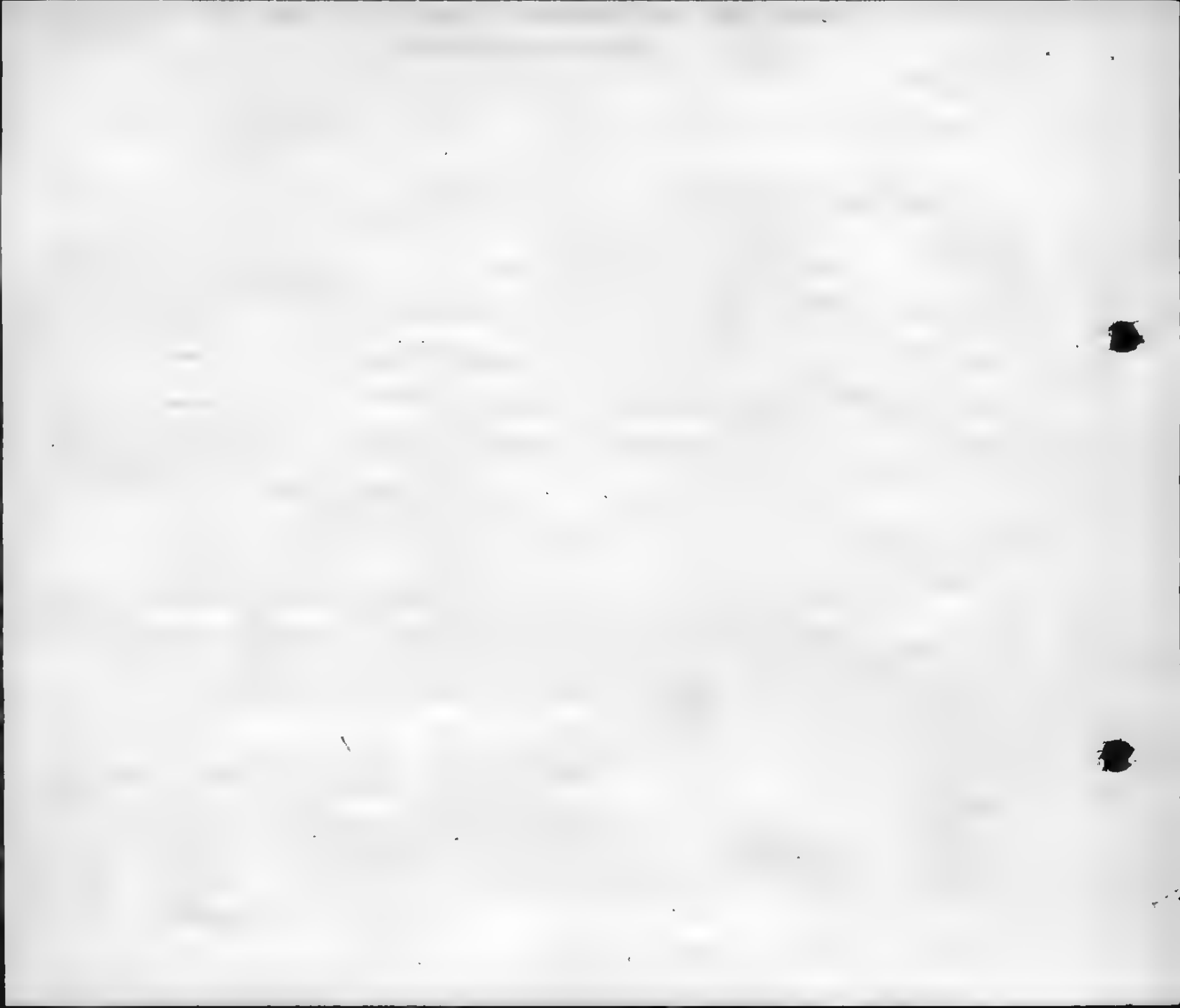
09222

9241

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 17 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS 3706 Lawrence Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Clarence Middle Wilbert Last Fox				4. DATE OF DEATH Month August Day 22 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/17/76		9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY Virginia		12. CITIZEN OF WHAT COUNTRY? America		
13. FATHER'S NAME Zachariah Fox			14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Archie Wilbert Fox		Address Rt. 2 Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Arteriosclerosis DUE TO (c) Generalized Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 16 days years						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8/5/58 19 to 8/22/58 19, that I last saw the deceased alive on 8/21/58 19, and that death occurred at 7A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10620 Georgia Ave Silver Spring, Md. DATE SIGNED 8/22/58							
ACTUAL SIGNATURE John J. Curry M.D. John J. Curry							
PHYSICIAN'S NAME (Type) John J. Curry							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/25/58		22c. NAME OF CEMETERY OR CREMATORY Mt. Zion		22d. LOCATION (City, town, or county) (State) Bethesda, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE AUG 25 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9242

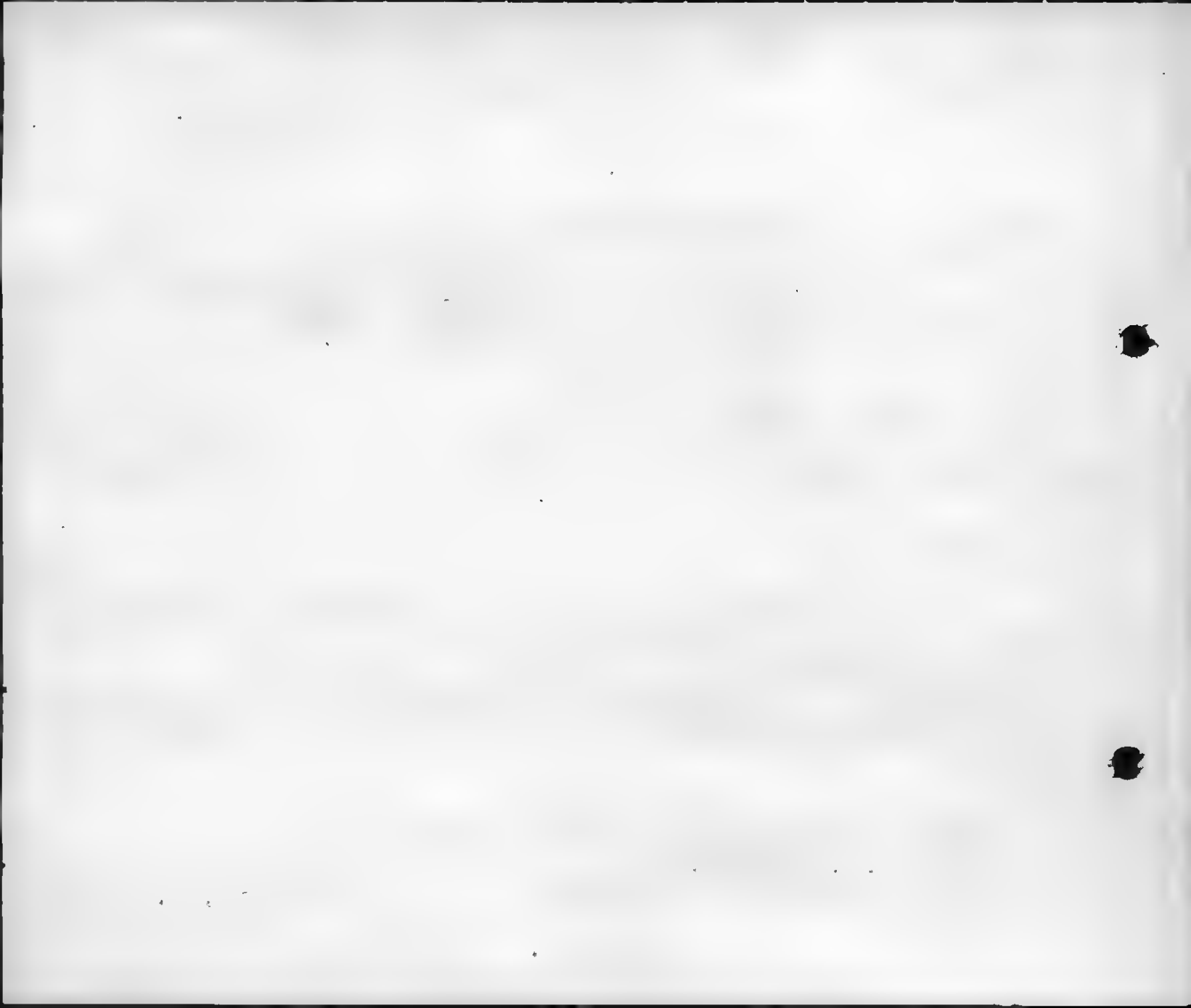
CERTIFICATE OF DEATH

09223

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 10 min.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Blanche Middle Irene Last Frazier				4. DATE OF DEATH Month August Day 4 Year 19 58			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/16/10	
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months 4 Days 4 Hours 19 Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Peyton E. Campbell				14. MOTHER'S MAIDEN NAME Mary White			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO		17. INFORMANT James Wilton Frazier Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) Heart							INTERVAL BETWEEN ONSET AND DEATH 1 hr 4 years 5 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/15/58 , 1958, to 8/4/58 , 1958, that I last saw the deceased alive on 7/28/58 , 1958, and that death occurred at 7:25 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE J. W. Bird, M. D.				ADDRESS (Street, city or town, state) Sandy Spring, Maryland			
PHYSICIAN'S NAME (Type) J. W. Bird, M. D.				DATE SIGNED 8/5/58			
22a. BURIAL, CREMATION, ETC. (Specify) Burial		22b. DATE THEREOF 8/8/58		22c. NAME OF CEMETERY OR CREMATORY Round Oak.,		22d. LOCATION (City, town, county) (State) Spencerville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden				ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR AUG 7 '58	
				24b. REGISTRAR'S SIGNATURE W. H. Houch			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is completely filled in by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9243

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>9402 Riley Place</i>		d. STREET ADDRESS <i>9402 Riley Place</i>	
3. NAME OF DECEASED (Type or print) <i>Charles Clifton Freer</i>		4. DATE OF DEATH <i>Aug. 6 1958</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9/16/80</i>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Vault Keeper</i>		9b. KIND OF BUSINESS OR INDUSTRY <i>Bur. Engraving</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Vault Keeper</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Bur. Engraving</i>	
11. BIRTHPLACE (State or foreign country) <i>Washington D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>William Freer</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Clark</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>wife, Mrs. Mary A. Freer, 9402 Riley Place</i>		Address <i>Silver Spring, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> DUE TO <i>Arteriosclerotic heart disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic heart disease</i> DUE TO (c) <i>Arteriosclerotic heart disease</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>None</i> p. m. <i>None</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>7/22, 1958</i> to <i>8/6, 1958</i> , that I last saw the deceased alive on <i>7/30, 1958</i> , and that death occurred at <i>3 P. M.</i> from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <i>8805 Conn. Ave.</i>		DATE SIGNED <i>8/6/58</i>	
ACTUAL SIGNATURE <i>John B. Umhan M.D.</i>		PHYSICIAN'S NAME (Type) <i>John B. Umhan Chery Close MD</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>8/9/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>CONGRESSIONAL CEMETERY</i>	22d. LOCATION (City, town, or county) (State) <i>WASHINGTON, D.C.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warner B. Humphrey</i>		ADDRESS <i>SILVER SPRING, MD.</i>	24a. REC'D BY REGISTRAR <i>AUG 11 '58</i>
		24b. REGISTRAR'S SIGNATURE <i>Al. Beach</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9244

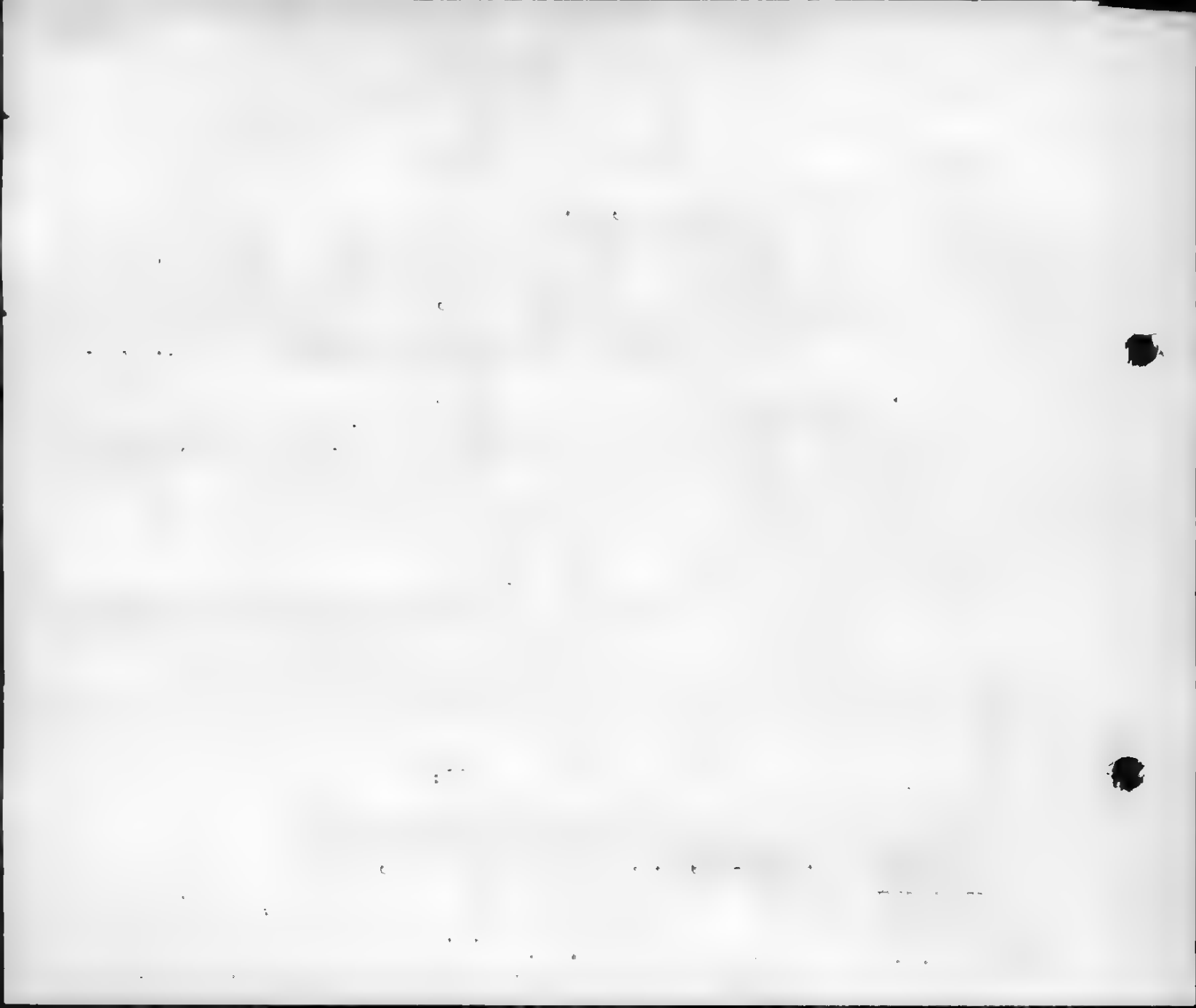
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Florida b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 4 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First David Middle Bryant Last Fussell				4. DATE OF DEATH Month August Day 7 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 15, 1949	
9. AGE (In years last birthday) 9 yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) District of Columbia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Albert L. Fussell				14. MOTHER'S MAIDEN NAME Lucille Gant			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema & congestion 754.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congenital Aortic Stenosis DUE TO (c) P.B.T. - atherosclerosis							INTERVAL BETWEEN ONSET AND DEATH 4 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 3, 1958 , to August 7, 1958 , that I last saw the deceased alive on August 7, 1958 , and that death occurred at 11:00p.m. from the causes and on the date stated above.							
ACTUAL SIGNATURE Carlos R. Lombardo M.D.				ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) CARLOS R. LOMBARDO, M.D.				DATE SIGNED 8/8/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) removal		22b. DATE THEREOF 8/9/58		22c. NAME OF CEMETERY OR CREMATORY Webster Cemetery		22d. LOCATION (City, town, or county) (State) Webster, Florida	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H.Hines Co., 2901 14th St. N.W.				ADDRESS Wash. D.C.		24a. REG'D BY REGISTRAR AUG 11 58 DATE	
				24b. REGISTRAR'S SIGNATURE Quintanilla			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be delivered for use as the burial-transit permit. These please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9245

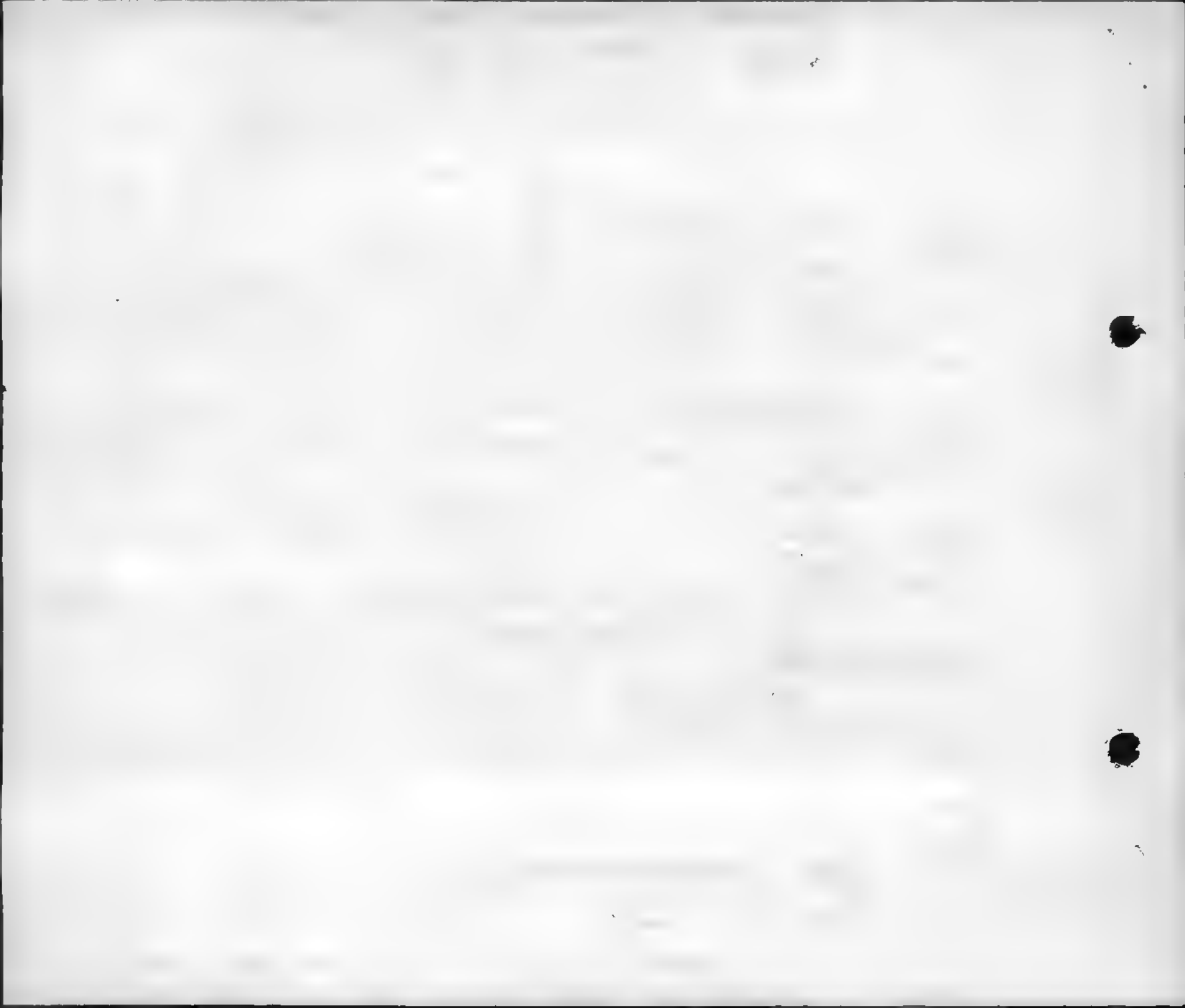
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Debarban</u>				d. STREET ADDRESS <u>Box 143, Rockville, Md</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Carmen C. Garber</u>				4. DATE OF DEATH Month Day Year <u>Aug. 16 1958</u>			
5. SEX <u>f</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/21/95</u>	9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min. <u>2 12 30</u>		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Peoria, Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Carl C. Christensen</u>				14. MOTHER'S MAIDEN NAME <u>Lois ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Edward J. Garber</u>		17. INFORMANT <u>Box 143, Rockville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracerebral hemorrhage, left hemisphere</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis, left middle cerebral art</u> DUE TO (c) <u>years</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 da</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January, 1917</u> , to <u>16 Aug, 1958</u> , that I last saw the deceased alive on <u>15 Aug, 1958</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. G. Hall</u>				ADDRESS (Street, city or town, state) <u>615 W. Montgomery Ave Rockville, Md</u>			
DATE SIGNED <u>8/14/58</u>							
PHYSICIAN'S NAME (Type) <u>W. G. HALL</u>				<u>615 W. Montgomery Ave Rockville Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Aug. 20, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co.</u>				ADDRESS <u>3072 MSt. N.W.</u>		24a. REC'D BY REGISTRAR DATE <u>Aug 19 58</u>	
				24b. REGISTRAR'S SIGNATURE <u>John A. Frank</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

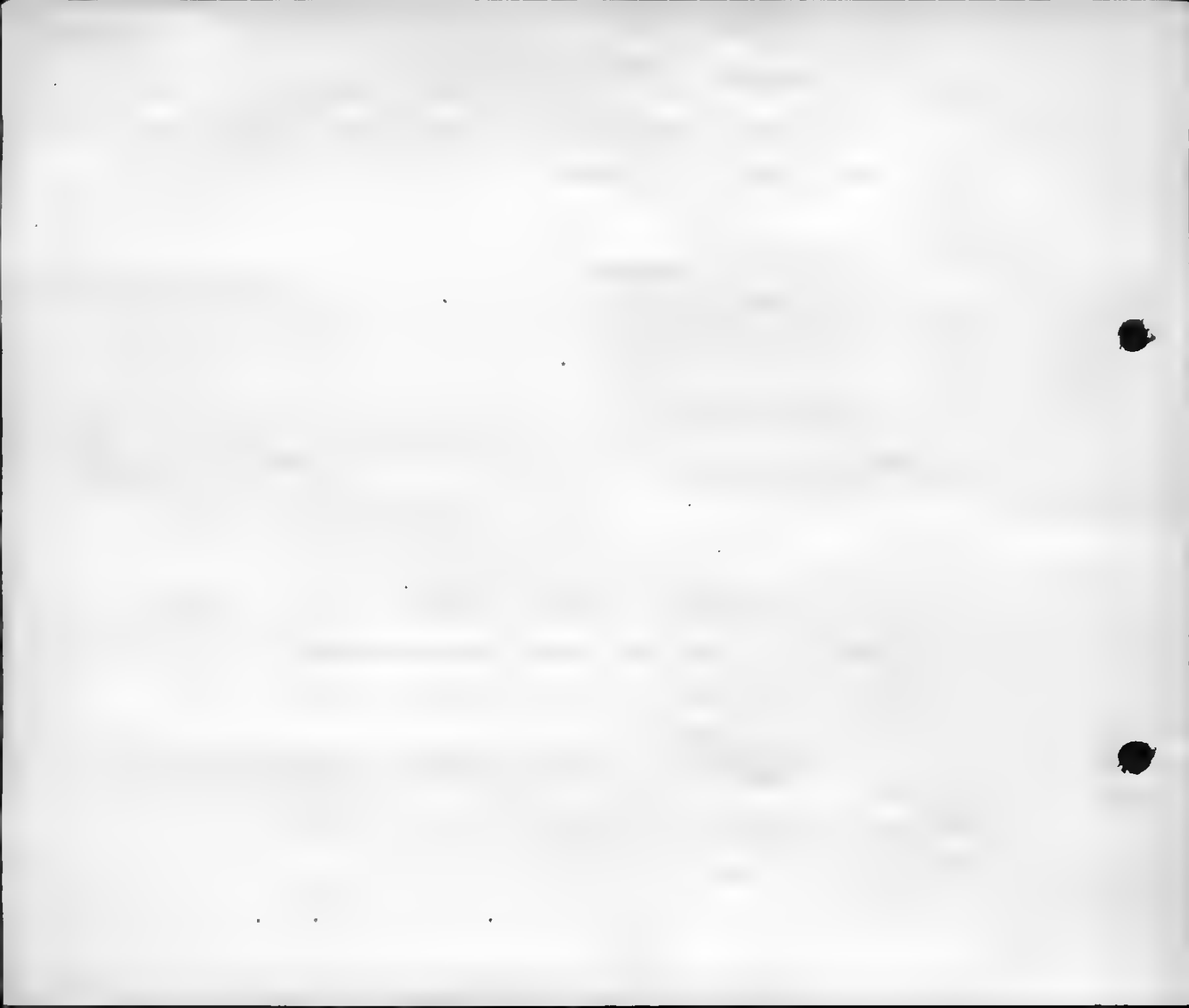
9185

CERTIFICATE OF DEATH

09227

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) a. STATE <u>DISTRICT OF Columbia</u> b. COUNTY <u>Washington D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN TB <u>11 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hosp</u>		d. STREET ADDRESS <u>1345 Madison St NW</u>	
3. NAME OF DECEASED (Type or print) <u>Edith Louise Gardner</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>28</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 4, 1881</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Teacher Rtd State of Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maine</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Joseph Perkins</u>		14. MOTHER'S MAIDEN NAME <u>Althea Stover</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Hospital Records</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal Failure with Uremia</u> <u>41 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Nephrosclerosis</u> (c) <u>Intestinal Obstruction due to Adhesions</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 17 1958</u> to <u>August 28 1958</u> , that I last saw the deceased alive on <u>August 28 1958</u> , and that death occurred at <u>959</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lyle Williams</u> M.D.		ADDRESS (Street, city or town, state) <u>8700 Columbia Rd S. 1 mi. S. of Spring</u>	
PHYSICIAN'S NAME (Type) <u>Lyle Williams</u>		DATE SIGNED <u>Aug 28, 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/30/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tiekner & Sons - Balto</u> ADDRESS <u>17</u>		24a. REC'D BY REGISTRAR <u>SEP 2 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

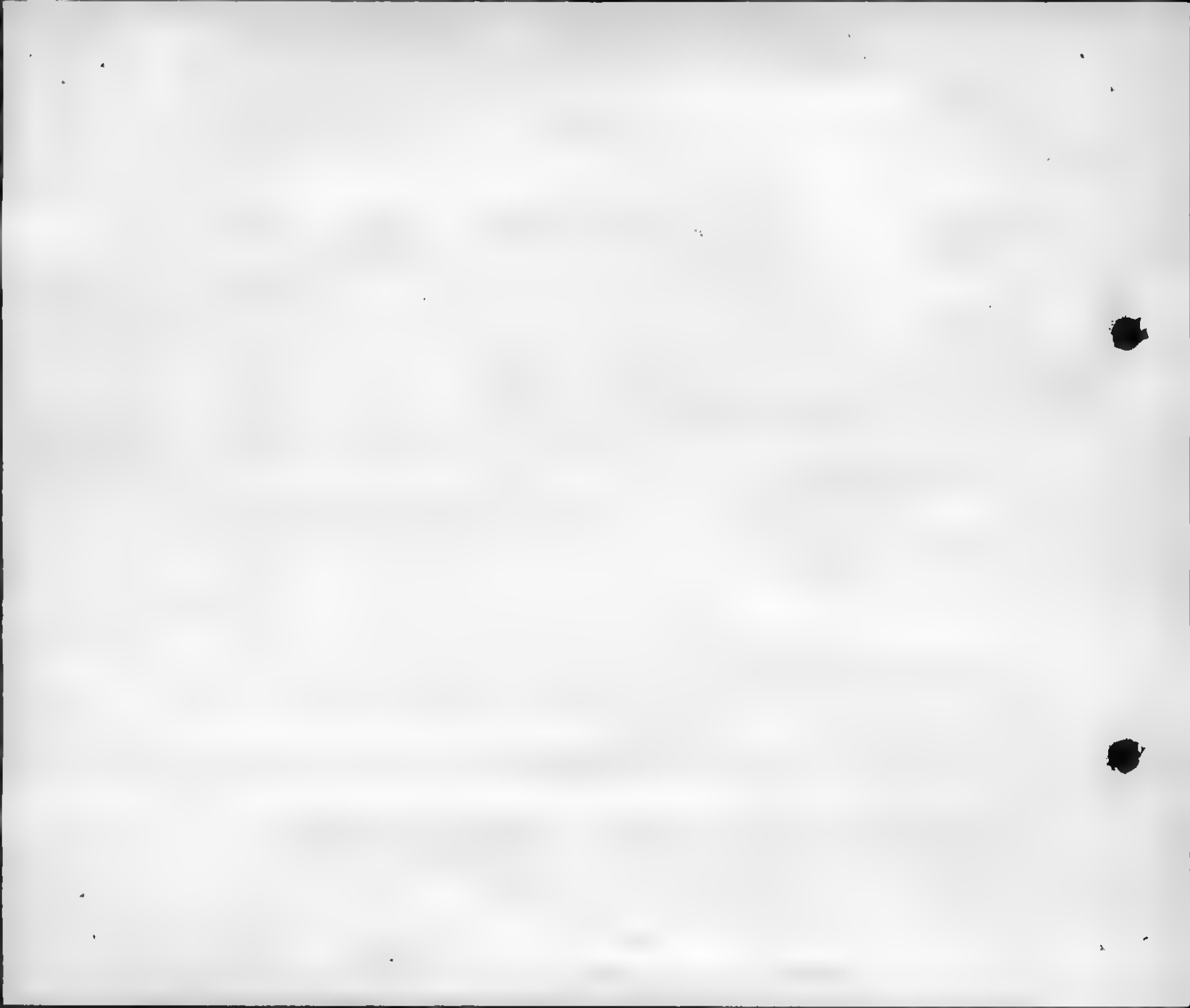
9246 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09228

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> D.O.A.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3414			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>1308 N. Charles St.</u>			
3. NAME OF DECEASED (Type or print) <u>MILTON THOMAS GASIOROWSKI</u>				4. DATE OF DEATH Month <u>8</u> Day <u>5</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5.7.18 1915</u>	
9. AGE (In years last birthday) <u>42</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>2</u>		IF UNDER 24 HRS. Hours <u>1</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>CARNIVAL</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>FRANCIS X GASIOROWSKI</u>				14. MOTHER'S MAIDEN NAME <u>ANASTAZIA</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>				16. SOCIAL SECURITY NO. <u>220-14-6998</u>		17. INFORMANT <u>FRANK GASIOROWSKI</u> Address <u>616 JEFFREY ST.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) <u>1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>1</u> INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>8-5-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Aug 9, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. STANISLAUS</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George G. Gonsa</u> ADDRESS <u>4001 Ritchie Hwy</u>				24a. REC'D BY REGISTRAR <u>AUG 11 2 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Funn</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File, page 1 and 2 with the registrar prior to burial, cremation, or removal.



9247

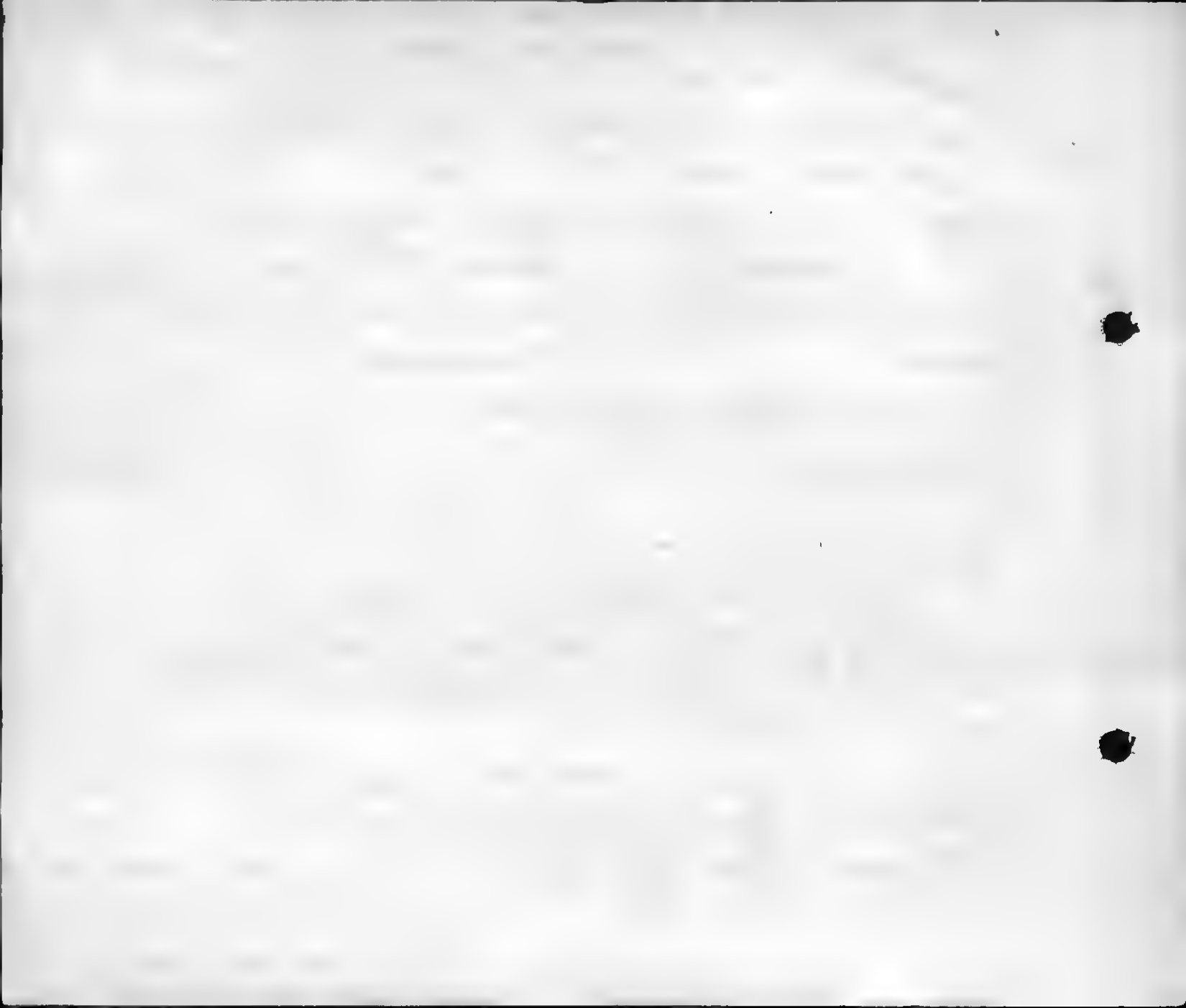
CERTIFICATE OF DEATH

09229

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Olney</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban Hospital</i>		d. STREET ADDRESS <i>Box 14</i>	
3. NAME OF DECEASED (Type or print) First <i>Henry</i> Middle <i>William</i> Last <i>Gossaway</i>		4. DATE OF DEATH Month <i>8</i> Day <i>6</i> Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>November 26, 1893</i>
9. AGE (In years lost birthday) <i>64</i> yrs.		10. IF UNDER 1 YEAR Months <i>9</i> Days <i>9</i> Hours <i>19</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Chaffeur</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>State Road Commission</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Henry Gossaway</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Holland</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>220-36-9982</i>	
17. INFORMANT <i>Wife Mrs William B. Gossaway Same</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Artery</i> <i>440X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>260X</i> (b) <i>Hypertensive Heart Disease</i> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Arteriosclerosis</i> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July 29, 1958</i> to <i>Aug 6, 1958</i> , that I last saw the deceased alive on <i>Aug 5, 1958</i> , and that death occurred at <i>4:00 P.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>1115 H. G. St.</i> <i>9/15/58</i> ACTUAL SIGNATURE <i>Robert R. Macdonald</i> M.D. PHYSICIAN'S NAME (Type) <i>R. L. Snowden</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8/9/58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Oak Grove</i>		22d. LOCATION (City, town, or county) (State) <i>Montgomery, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. L. Snowden</i>		24a. REC'D BY REGISTRAR <i>Aug 11 '58</i>	
ADDRESS <i>Rockville, Md.</i>		24b. REGISTRAR'S SIGNATURE <i>Robert R. Macdonald</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is to be completely filled in by the funeral director. Page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9248

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 1 filed 232 8-18-58 et

CERTIFICATE OF DEATH

09230

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town). <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Daughter's home</u>		d. STREET ADDRESS <u>1610 University Blvd. East</u>	
3. NAME OF DECEASED (Type or print) First <u>Ruth</u> Middle <u>Stanford</u> Last <u>Watling</u>		4. DATE OF DEATH Month <u>August</u> Day <u>5</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3 Sept 1895</u>
9. AGE (In years last birthday) <u>62 yrs.</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Dothan, Alabama</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Will Stanford</u>		14. MOTHER'S MAIDEN NAME <u>Nannie Story</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Daughter</u>		Address <u>610 University Blvd. East Silver Spring, Md.</u>	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO <u>& generalized arteriosclerosis.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>20X</u> (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 years</u> <u>15 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus - Gastrointestinal Bleeding</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4 August 1958</u> to <u>5 August 1958</u> , that I last saw the deceased alive on <u>4 August 1958</u> , and that death occurred at <u>8:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Russell B. Arnold</u> M.D.		ADDRESS (Street, city or town, state) <u>5801 Colverville Rd. Md.</u> DATE SIGNED <u>8/5/58</u>	
PHYSICIAN'S NAME (Type) <u>Russell B. Arnold</u>		<u>Silver Spring, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug-9-1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oakwood</u>		22d. LOCATION (City, town, or county) (State) <u>Reisterstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u>		ADDRESS <u>254 Central St. Silver Spring, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>AUG 7 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur Walters</u>	



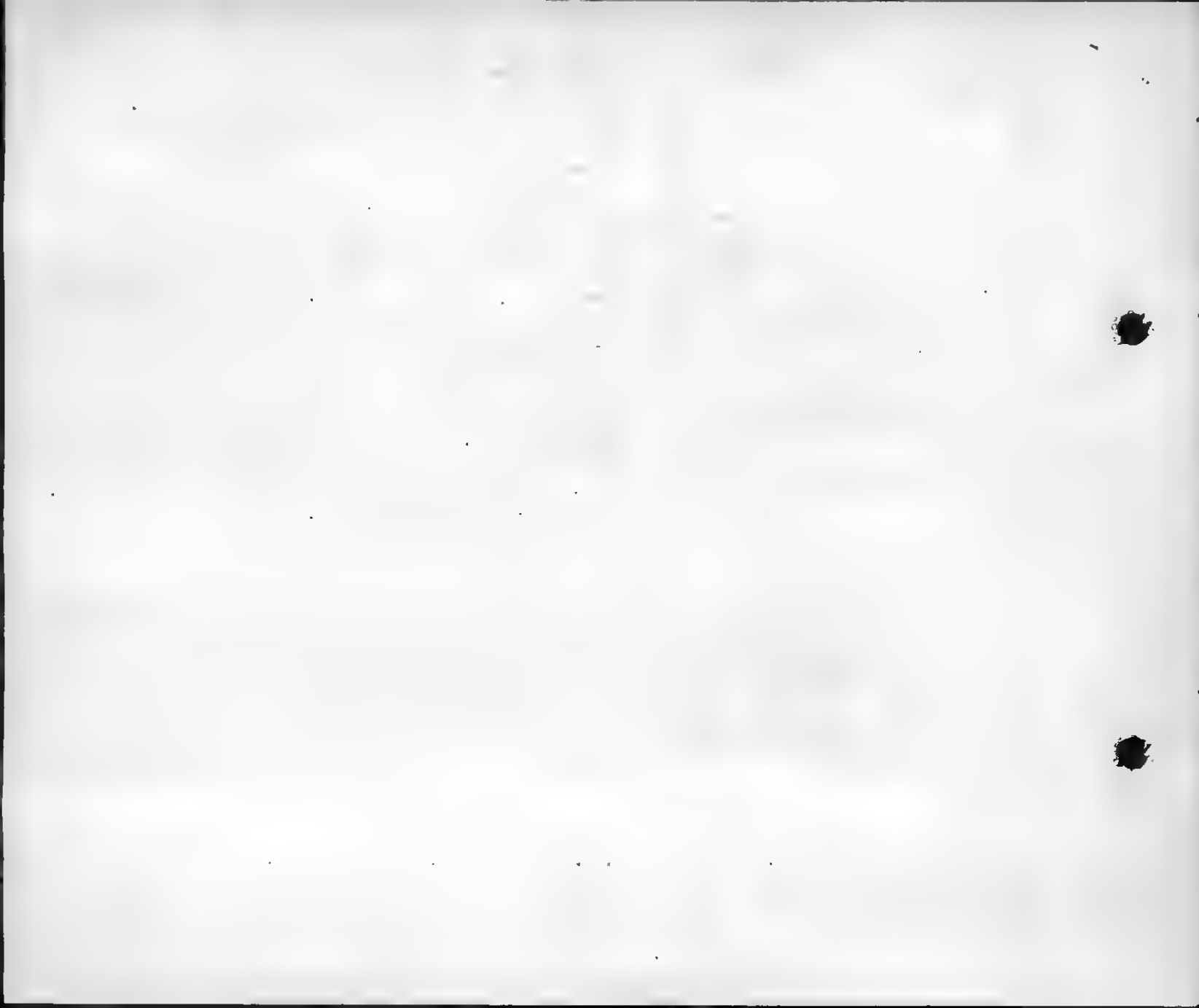
9249

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5304 Flanders Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Victoria Middle GOFFREDO Last GOFFREDO		4. DATE OF DEATH Month August Day 3 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 15, 1895
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR: Months 3 Days 18	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Francisco Iafolla		14. MOTHER'S MAIDEN NAME Angelina Grasso	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 232-58-2872	
17. INFORMANT Angelo G. Goffredo-Same Item #2-husband		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure and pulmonary edema DUE TO Carcinoma of tongue with cervical lymph node metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO (b) lymph node metastases DUE TO (c) lymph node metastases		INTERVAL BETWEEN ONSET AND DEATH 2-3 Hrs. 3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 3, 1958 to August 3, 1958 , that I last saw the deceased alive on August 3, 1958 , and that death occurred at 10:25 P.M. , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Andrew J. Brennan M.D.			
PHYSICIAN'S NAME (Type) Andrew J. Brennan, M.D. 4630 Montgomery Ave. Bethesda, Md 8/4/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/7/48	
22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		22d. LOCATION (City, town, or county) (State) Silver Spring Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md		24a. REC'D BY REGISTRAR DATE AUG 6 '58	
24b. REGISTRAR'S SIGNATURE W. H. ...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and is to be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and is hereby filed in by the funeral director, page 3 should be detached and use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

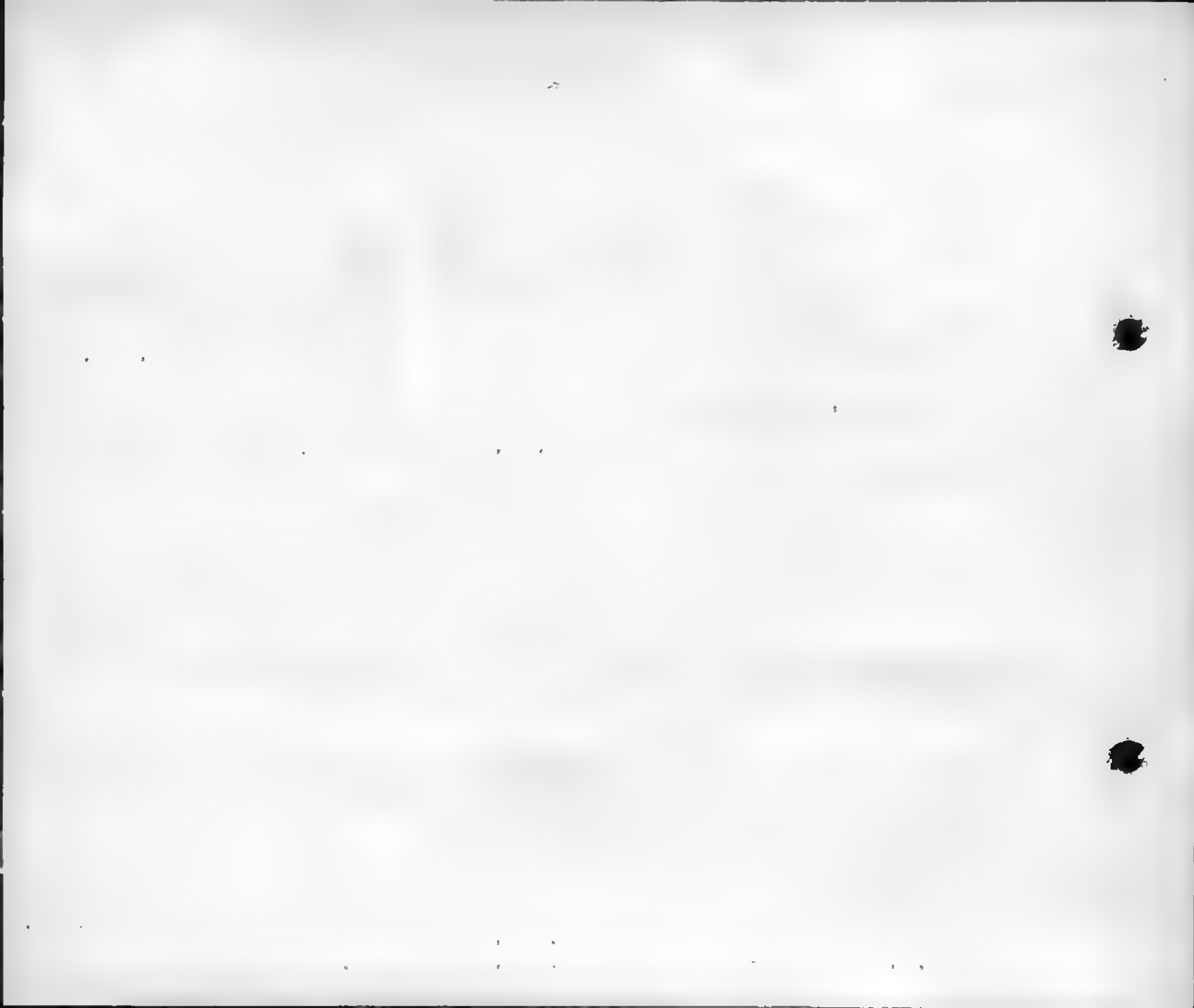
9250

CERTIFICATE OF DEATH

09232

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6302 Valley Road		d. STREET ADDRESS 6302 Valley Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Julia Middle Darden Last Goolsby		4. DATE OF DEATH Month August Day 26 , Year 19 58	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/24/1878
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Sanford M. Warren		14. MOTHER'S MAIDEN NAME Mary Louisa Edwards	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO	
17. INFORMANT S. M. Warren		Address 6302 Valley Road, Bethesda, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pelvic Carcinoma PROBABLY OVARIAN 175.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) With extension to intestine - DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 19 53 to Aug 26 19 58 , that I last saw the deceased alive on Aug 20 19 58 , and that death occurred at 10 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Richard E. DeButts		ADDRESS (Street, city or town, state) DATE SIGNED 8/26/58	
M.D. 1150 Conn. Ave. N.W. DC			
PHYSICIAN'S NAME (Type) RICHARD E. DEBUTTS			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/28/1958	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.-2901 14th St., N.W.		ADDRESS Wash. D.C.	
24a. REC'D BY REGISTRAR DATE AUG 27 1958		24b. REGISTRAR'S SIGNATURE Julius S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9251

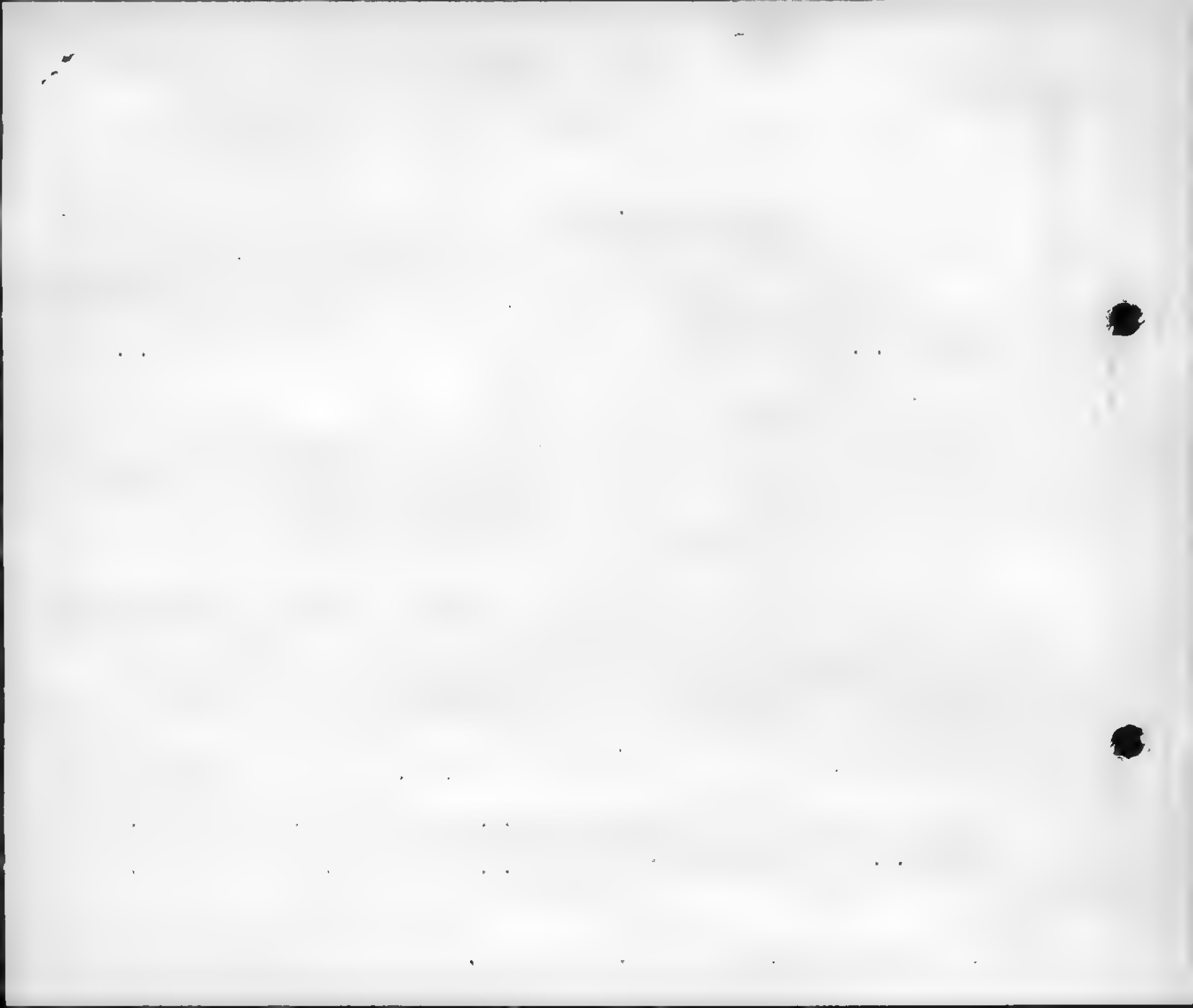
CERTIFICATE OF DEATH

Reg. Dist. No. 215

09233

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 38 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. STREET ADDRESS Post Office Box 32			
3. NAME OF DECEASED (Type or print) First Middle Last Walter Horace GRAHAM				4. DATE OF DEATH Month Day Year August 13 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 June 1886	9. AGE (In years last birthday) yrs. 72	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner, U.S. Marine Corps, Retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Arkansas		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George W. GRAHAM				14. MOTHER'S MAIDEN NAME Mary HILL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW-I		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Son, Walter Harry Graham (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma right lung with DUE TO (b) metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 6 months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6 July 1958 , to 13 August 1958 , that I last saw the deceased alive on 12 August 1958 , and that death occurred at 5:20 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE J. E. McClenathan				ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 8-13-58			
PHYSICIAN'S NAME (Type) J. E. MC CLENATHAN, CDR, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-15-58		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Humphrey				ADDRESS 255 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR AUG 1 1958	
				24b. REGISTRAR'S SIGNATURE W. J. Humphrey			

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



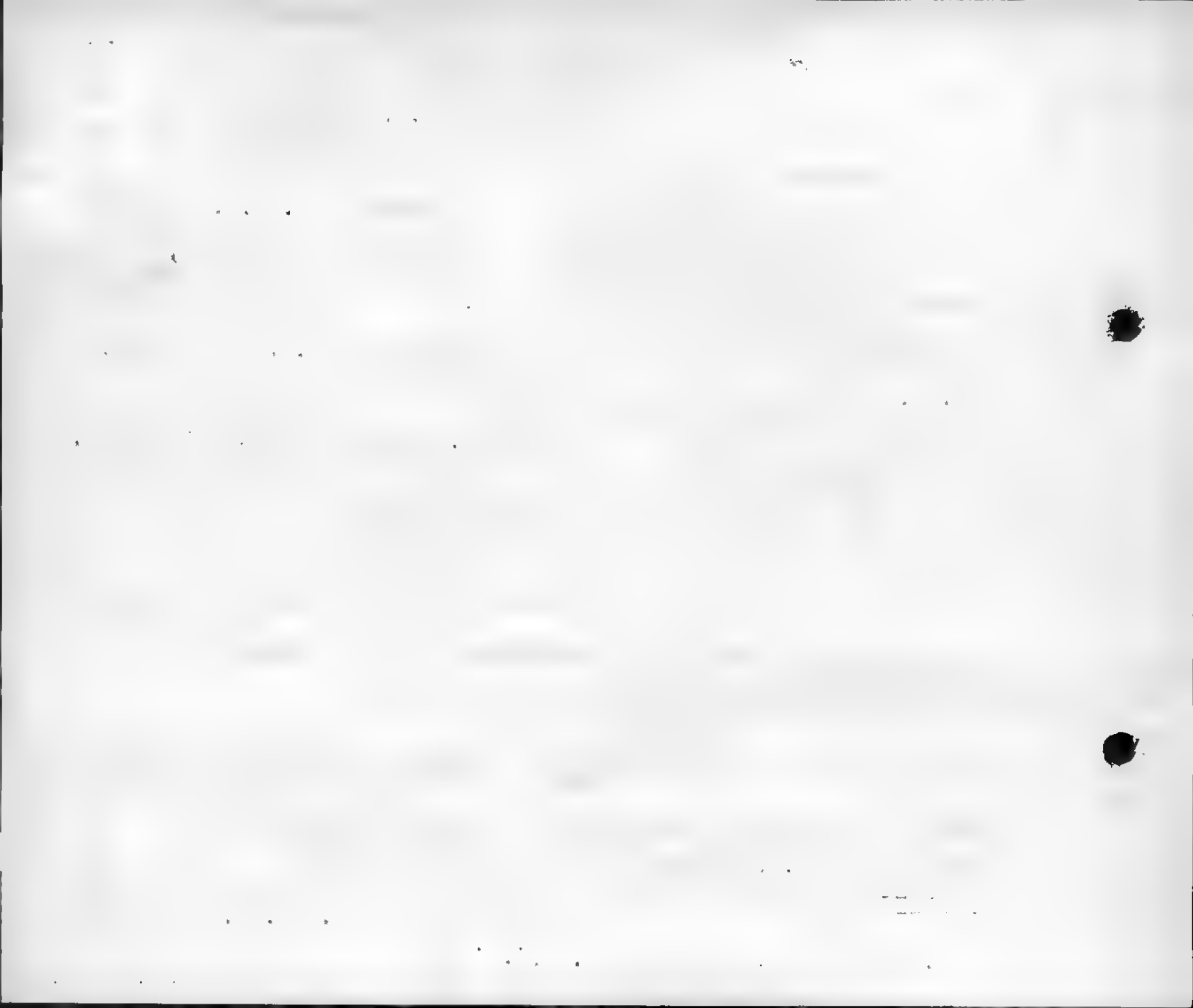
9252

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Marylander Home of Rest		d. STREET ADDRESS 1817 Lamont St. N.W.	
3. NAME OF DECEASED (Type or print) First Sue Middle Crossman Last Gray		4. DATE OF DEATH Month August Day 1 Year 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 1, 1882
9. AGE (In years last birthday) 76 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wm. D. Crossman		14. MOTHER'S MAIDEN NAME Ida Cain	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT George V. Menke,		Address Barnesville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) Generalized arteriosclerosis, severe			INTERVAL BETWEEN ONSET AND DEATH 1 mo. 1 yr. 5 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture, left hip, 2/3/58			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 29, 1958 , to Aug 1, 1958 , that I last saw the deceased alive on Aug 1, 1958 , and that death occurred at 10:30 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas A. N. Hindman M.D.		ADDRESS (Street, city or town, state) 3935 Baltimore St. Kensington	
PHYSICIAN'S NAME (Type) Thomas A. N. Hindman		DATE SIGNED 8/1/58	
22a. BURIAL, CREMATION, REMOVAL SPECIAL	22b. DATE THEREOF 8/4/58	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22d. LOCATION (City, town, or county) (State) Pr. Geo. Co. Maryland
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W.		24a. REC'D BY REGISTRAR Aug 4 '58	24b. REGISTRAR'S SIGNATURE Alfred

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon paper and return to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



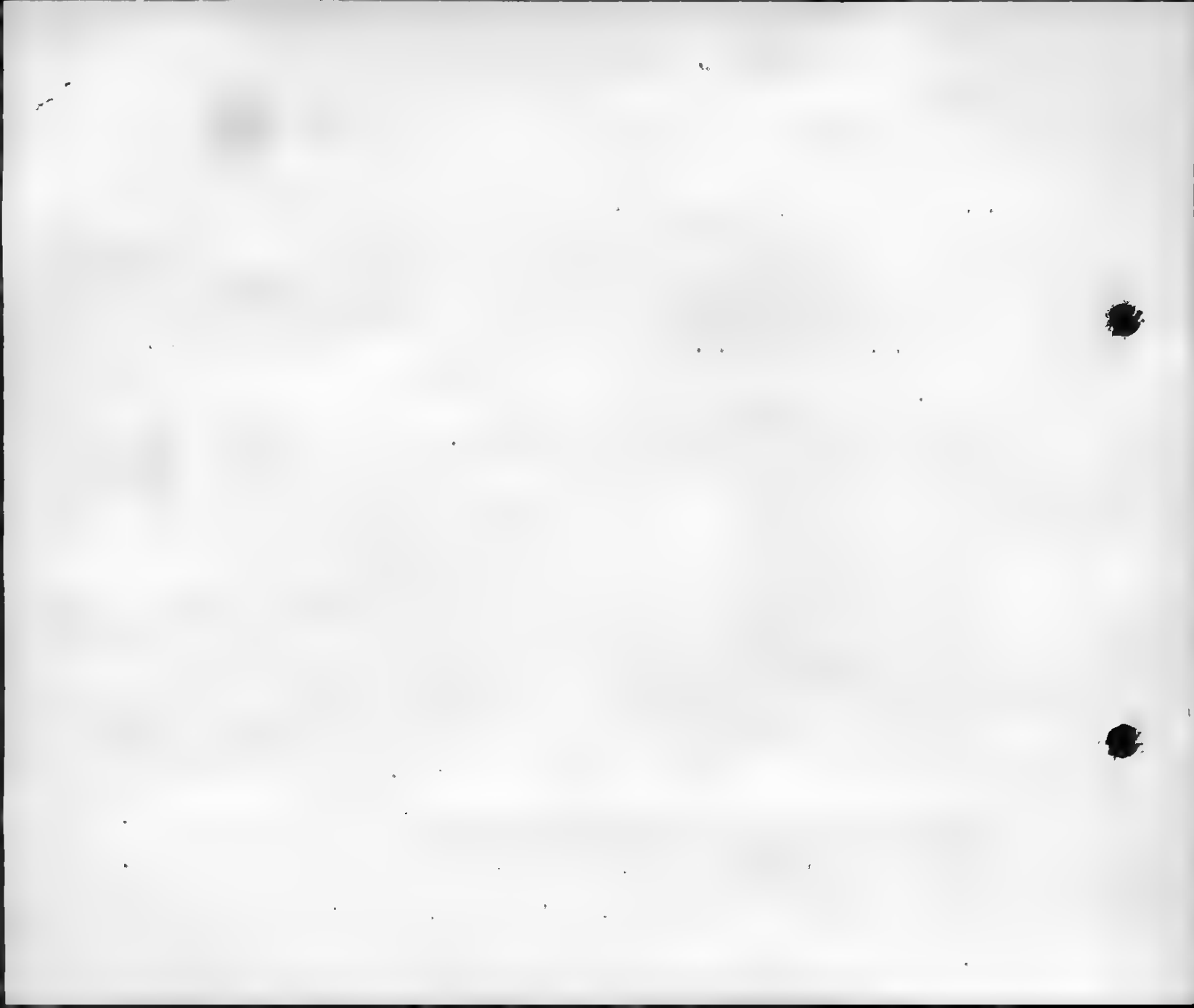
9253

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 2 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 5003 Euclid Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edward Middle James Last HAGEN				4. DATE OF DEATH Month August Day 11 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 26 April 1908		9. AGE (In years last birthday) 50 yrs	IF UNDER 1 YEAR Months Days Hours M'n.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner, U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Harry G. HAGEN				14. MOTHER'S MAIDEN NAME Josephine MOBLEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO (If yes, give war or dates of service) WW-II		17. INFORMANT Address (Wife) Mrs. Zena Hagen (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: 150X IMMEDIATE CAUSE (a) PNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) TRACHEO-ESOPHAGEAL FISTULA DUE TO (c) CARCINOMA OF ESOPHAGUS						INTERVAL BETWEEN ONSET AND DEATH 3 DAYS 2 MONTHS 2 YRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9 August , 19 58 , to 11 August , 19 58 , that I last saw the deceased alive on 11 August , 19 58 , and that death occurred at 8:50 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED George W. Taylor, Jr. M.D. U.S. Naval Hospital, Bethesda, Md. 8-12-58							
ACTUAL SIGNATURE George W. Taylor, Jr.		PHYSICIAN'S NAME (Type) GEORGE W. TAYLOR, CDR, MC, USN U.S. Naval Hospital, Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-14-58		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR Aug 14 '58	
24b. REGISTRAR'S SIGNATURE John S. Hagan							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9254

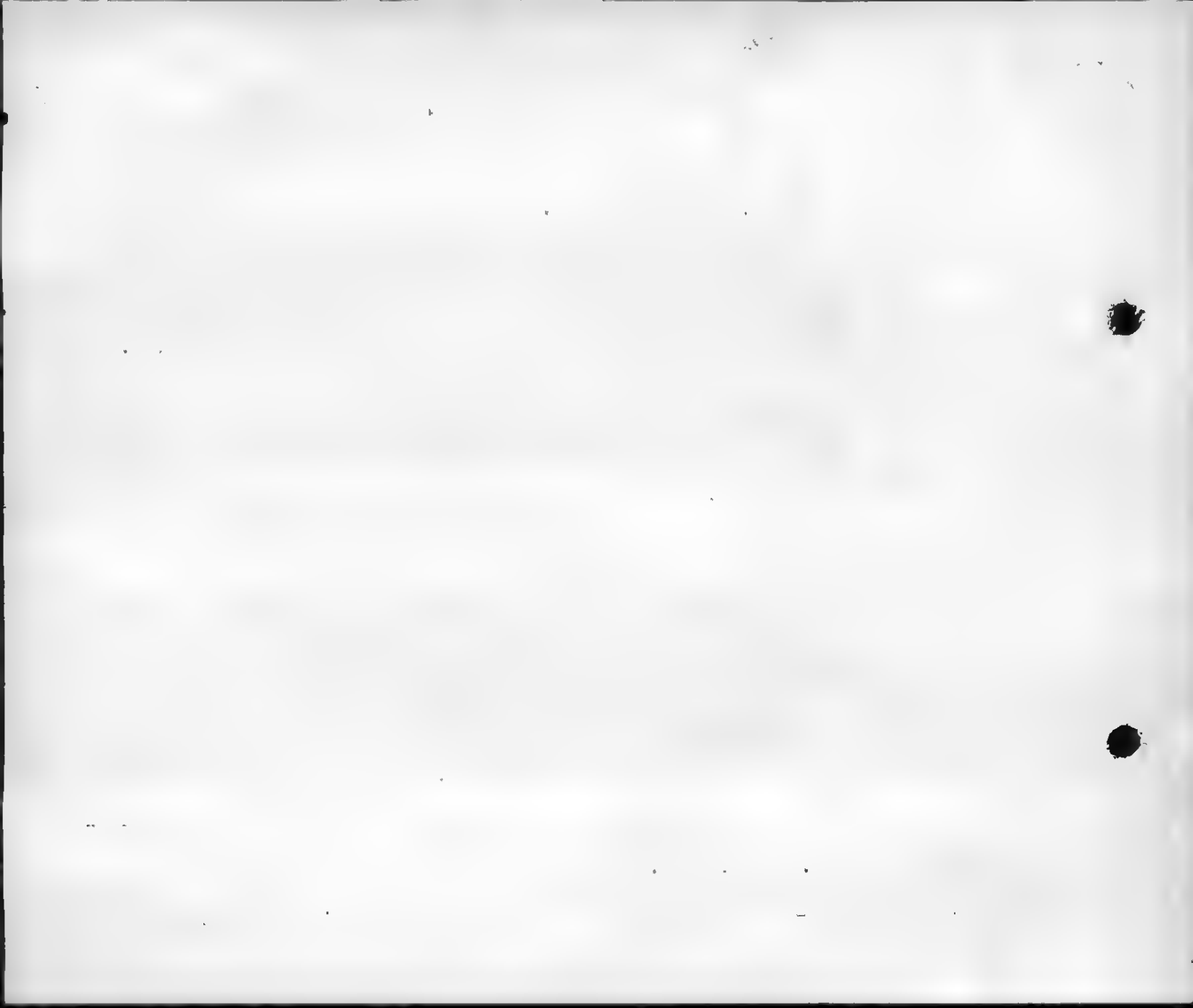
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 10 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE Virginia b. COUNTY Frederick c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gainesboro d. STREET ADDRESS (none) e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Catherine Last Haines				4. DATE OF DEATH Month August Day 27 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 10, 1918	
9. AGE (In years last birthday) yrs. 40		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME Robert Nixon			
14. MOTHER'S MAIDEN NAME Ethel Mullin				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. Unascertainable				17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction - anteroseptal 4:00.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Coronary Artery disease - severe DUE TO Fibrinolytic nodule - R.U.L. (c) Central + peripheral Left Tibia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 - 2 weeks							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 17, 1958 to August 27, 1958 , that I last saw the deceased alive on August 27, 1958 , and that death occurred at 7:05 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Leon G. Smith		M.D.		ADDRESS (Street, city or town, state) The Clinical Center		DATE SIGNED 8-27-58	
PHYSICIAN'S NAME (Type) Leon G. Smith, M.D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit		22b. DATE THEREOF 8-29-58		22c. NAME OF CEMETERY OR CREMATORY Capon Chapel Cemetery		22d. LOCATION (City, town, or county) (State) Hampshire County, W. Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert W. Humphreys		ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR SEP 2 '58		24b. REGISTRAR'S SIGNATURE Carl E. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



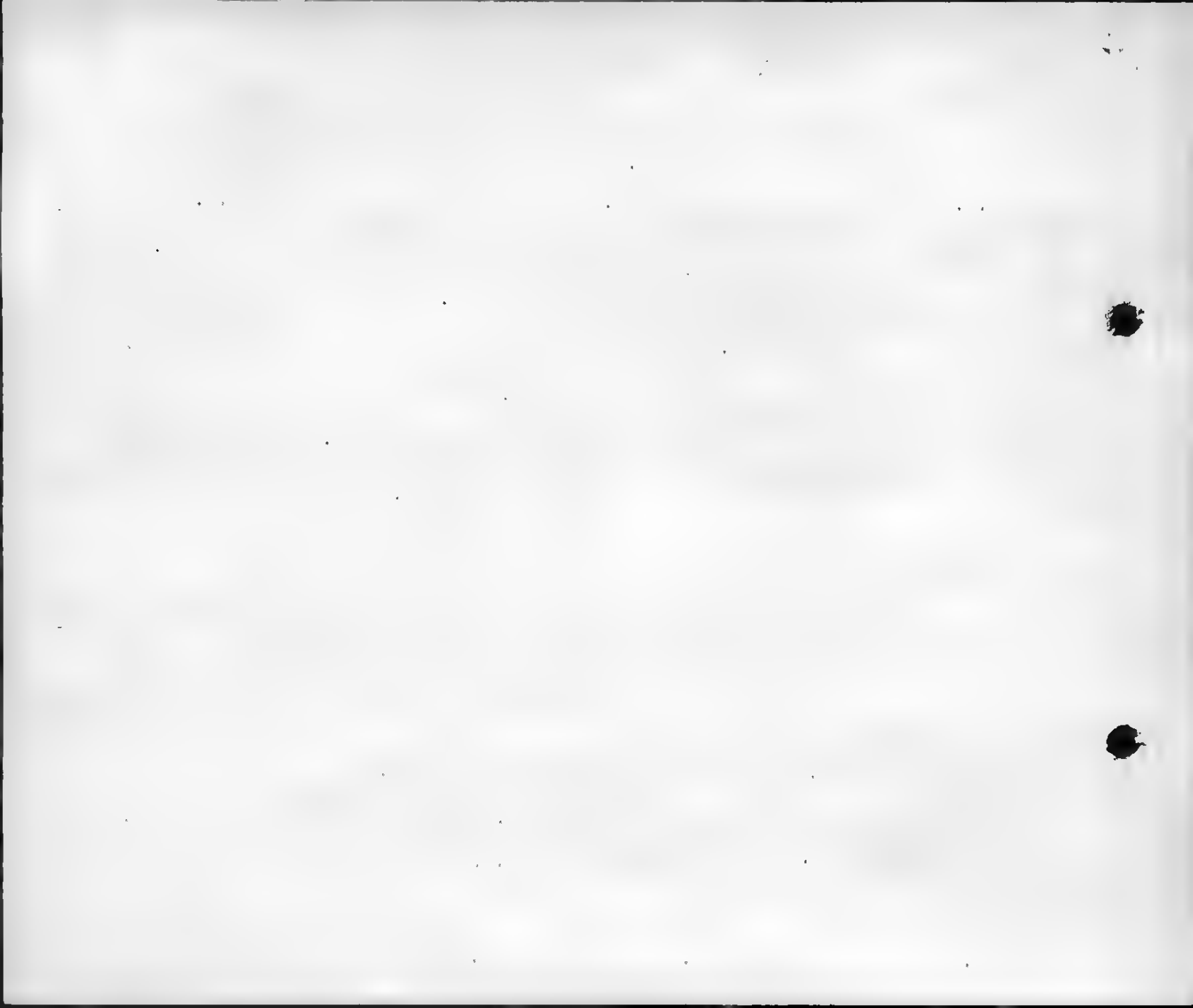
1. **MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**
9255
CERTIFICATE OF DEATH

09237

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47x	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 2131 Yorktown Rd. N.W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle (nmn) Last HALLA		4. DATE OF DEATH Month August Day 29 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 19 Sept. 1897
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Marine Corps	
11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Herman HALLA		14. MOTHER'S MAIDEN NAME Minnie MUCH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW-I & II		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT (Wife) Mrs. Blanche R. HALLA (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of esophagus DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4 May , 19 58 , to 29 August , 19 58 , that I last saw the deceased alive on 28 August , 19 58 , and that death occurred at 4:30A , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md.	
ACTUAL SIGNATURE Gerald D. Faulkner M.D.		DATE SIGNED 8-29-58	
PHYSICIAN'S NAME (Type) Gerald D. Faulkner, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md. 8-29-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-2-58	
22c. NAME OF CEMETERY OR CREMATORY Arlington Natl Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE S.H. Hines, 2901 14th St., N.W. Washington, D.C.		24a. REC'D BY REGISTRAR SEP 2 '58	
ADDRESS		24b. REGISTRAR'S SIGNATURE Gerald D. Faulkner	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9256

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admision) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>				c. LENGTH OF STAY IN 1b <u>13 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>				e. STREET ADDRESS <u>16923 CLAKENDON RD.</u>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>CATHERINE</u> Last <u>HAMILTON</u>				4. DATE OF DEATH Month <u>AUG</u> Day <u>7</u> Year <u>1958</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB 2 18 77</u>	
9. AGE (In years last birthday) <u>81</u> yrs		IF UNDER 1 YEAR Months <u>6</u> Days <u>5</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>BALTO - MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>LOHMAN</u>				14. MOTHER'S MAIDEN NAME <u>MARY C. H.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>577-50-5861</u>		17. INFORMANT <u>Son</u>		Address <u>Edward O Hamilton-5419 Uppingham St. Ch.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>several year</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>BRONCHO PNEUMONIA</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>May</u> Day <u>8</u> Year <u>1958</u> Hour a. m. <u></u> p. m. <u></u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Washington Clinic Wash DC</u>	
20f. (City or town) <u>Washington</u>				(County) <u></u>		(State) <u>DC</u>	
21. I certify that I attended the deceased from <u>May 8, 1958</u> to <u>Aug 7, 1958</u> , that I last saw the deceased alive on <u>Aug 7, 1958</u> , and that death occurred at <u>12:30 PM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Michel M. Healy</u>				DATE SIGNED <u>8/7/58</u>			
PHYSICIAN'S NAME (Type) <u>Michel M. Healy</u>				<u>Washington Clinic, Wash. D. C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/9/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Congressional</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. A. Humphrey</u> ADDRESS <u>Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>AUG 11 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon payment. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



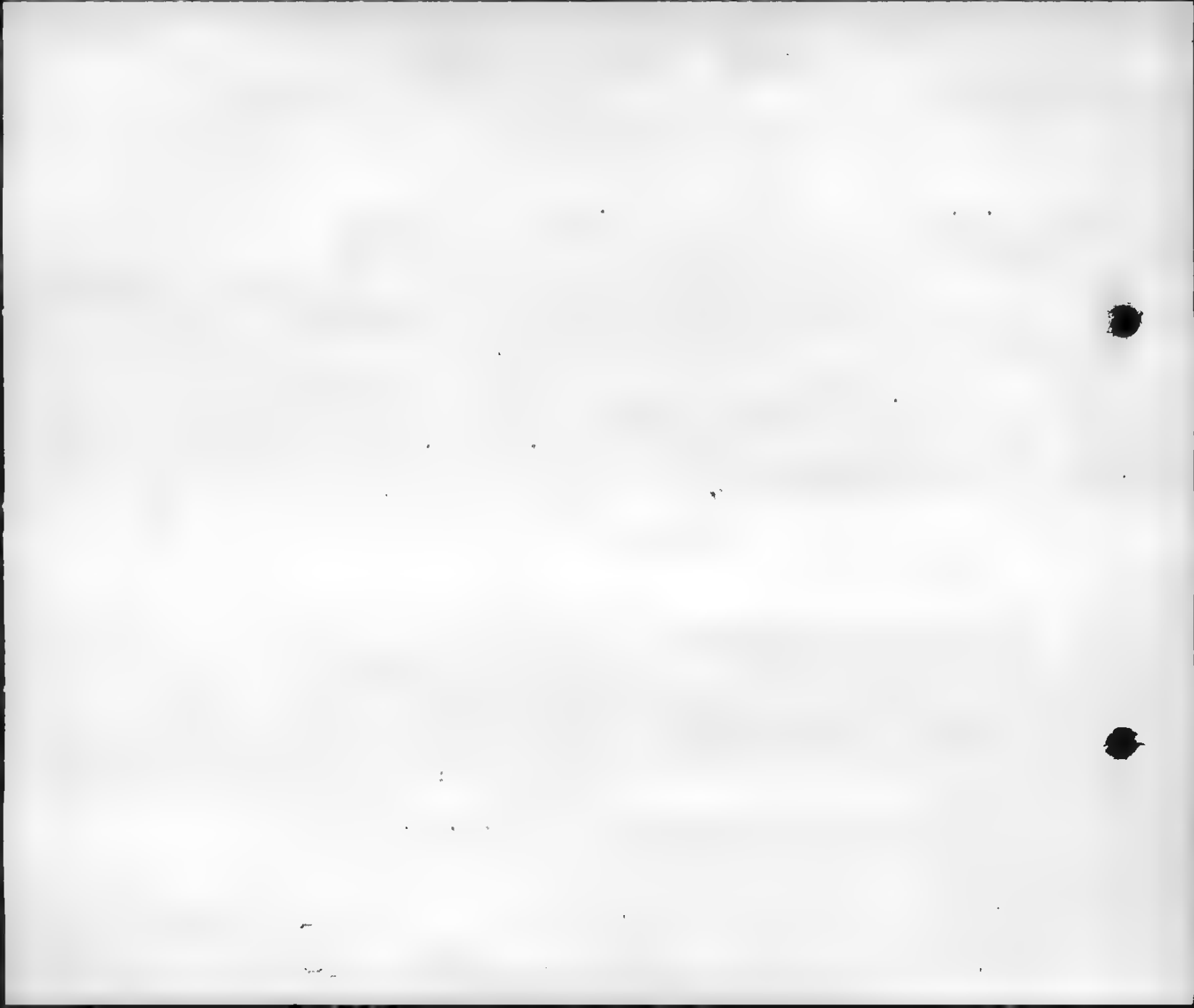
9257

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital, Bethesda, Md.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Hugh Middle Groseclose Last HARMON			4. DATE OF DEATH Month August Day 9 Year 19 58		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-2-12	9. AGE (In years last birthday) 46 yrs.	IF UNDER 1 YEAR: Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY Landscaping		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Samuel T. HARMON		
14. MOTHER'S MAIDEN NAME Ella MAE GROSECLOSE			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) [If yes, give war or dates of service] No		
16. SOCIAL SECURITY NO. 219-03-1511			17. INFORMANT Address Mrs. Alice R. HARMAN (Wife), same as #2 above		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage, subarachnoid DUE TO 330X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 22 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) fall		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from August 8 , 19 58 , to August 9 , 19 58 , that I last saw the deceased alive on August 9 , 19 58 , and that death occurred at 6:55A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) U. S. Naval Hospital, NMMC Bethesda 14, Maryland DATE SIGNED 8-9-58					
ACTUAL SIGNATURE Thomas A. Smith M.D. U. S. Naval Hospital, NMMC 8-9-58					
PHYSICIAN'S NAME (Type) Thomas A. SMITH LT MC USN Bethesda 14, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-12-58		22c. NAME OF CEMETERY OR CREMATORY Forest Oak	
22d. LOCATION (City, town, or county) (State) Gaithersburg, Maryland		23. FUNERAL DIRECTOR'S SIGNATURE R. A. PUMPHREY ADDRESS R. A. PUMPHREY FUNERAL HOME, ROCKVILLE, MD.			
24a. REC'D BY REGISTRAR AUG 12 1958		24b. REGISTRAR'S SIGNATURE Arthur L. Francis			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached and use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9-17-1234 9-2-54 et

CERTIFICATE OF DEATH

09240

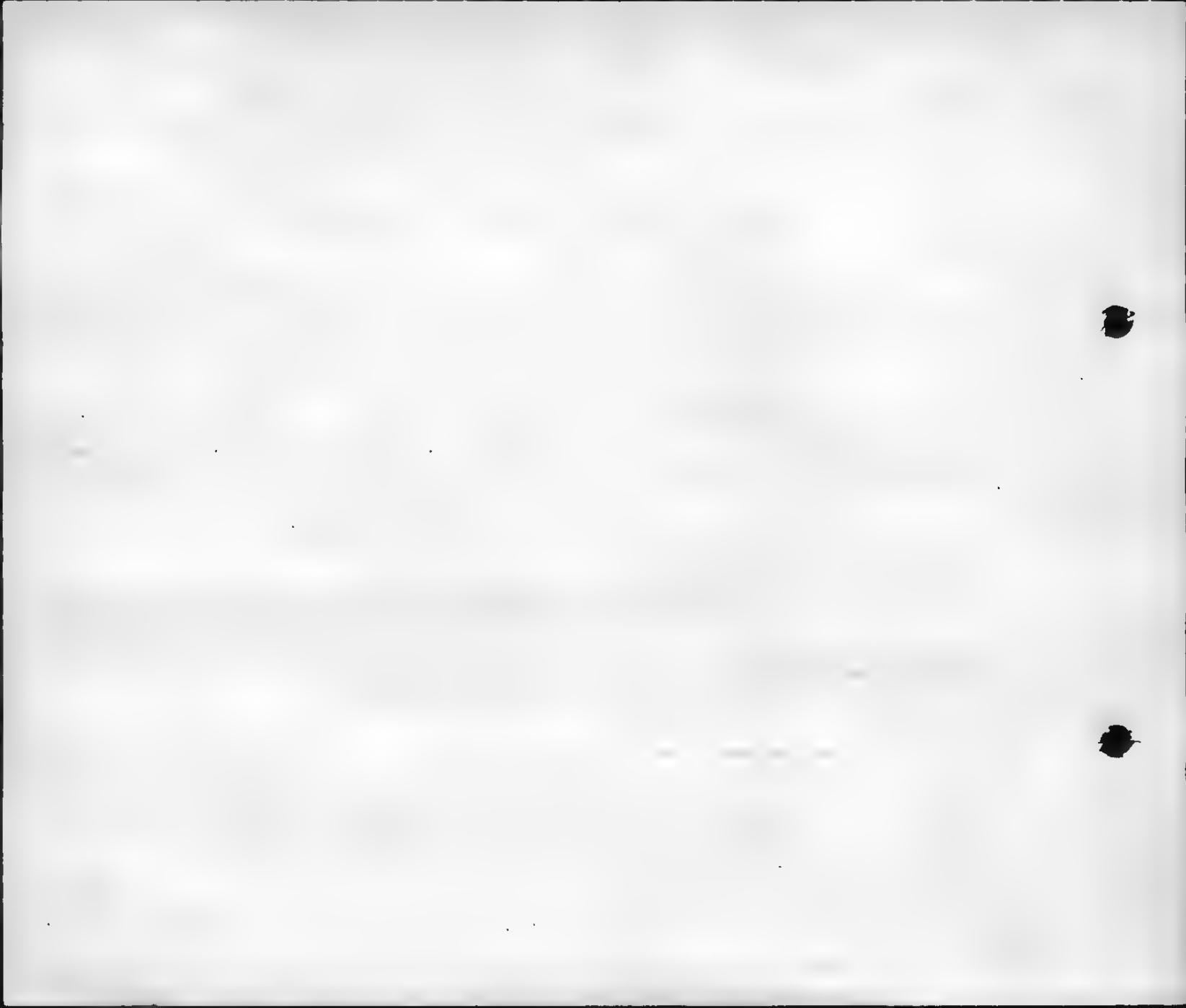
Reg. Dist. No.

9199

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Coleman Manor</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>405 Baltimore Ave.</u>		d. STREET ADDRESS <u>3406-39th street</u>	
3. NAME OF DECEASED (Type or print) <u>Rosa E. Harris</u>		4. DATE OF DEATH Month <u>8</u> Day <u>19</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/4/83</u>
9. AGE (In years last birthday) <u>74 7/8</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Claysville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John H. Fisher</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ellen Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Clifton A. Harris Hyattsville, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Carcinoma of bladder</u> DUE TO (c) <u>4-6 mos</u> Interval between onset and death <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-11</u> , 19 <u>58</u> , to <u>8-19</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8-18</u> , 19 <u>58</u> , and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. G. Hall</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>M.D. 615 W. Montgomery Ave - Rockville, Md. 8-19-58</u>	
PHYSICIAN'S NAME (Type) <u>W. G. Hall</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>8/27/58</u>	<u>Fort Lincoln</u>	<u>Coleman Manor Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Halley's Funeral Home Inc.</u>		24a. REC'D BY REGISTRAR <u>AUG 22 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

MEDICAL CERTIFICATION

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and duly filled in by the funeral director, Pages 1 and 2 should be filed with page 3 should be detached and use as the burial-transit permit. Then please remove carbon plan the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9258 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

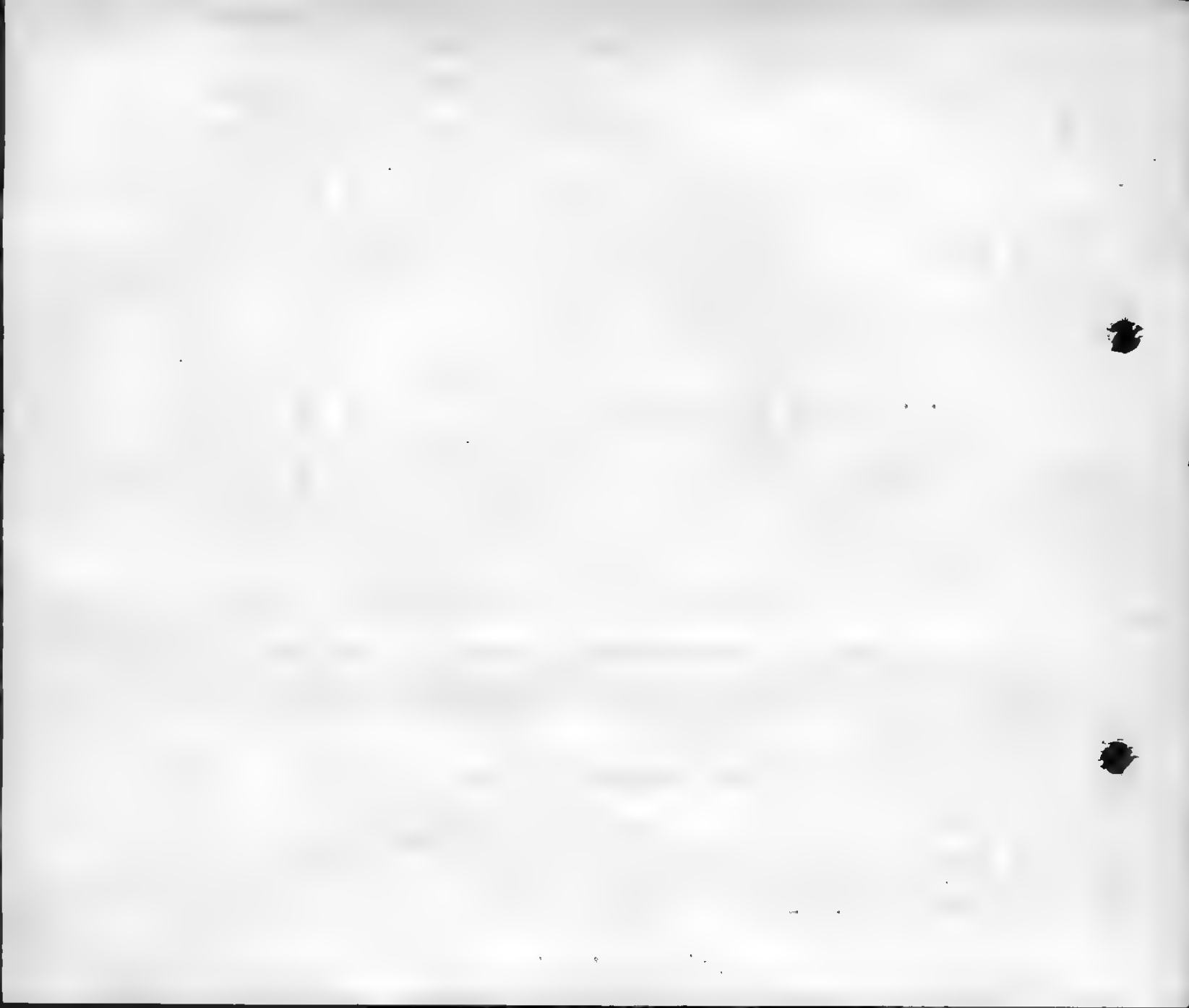
09241

Reg. Dist. No.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. If any delay is necessary, please execute the certificate, using the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. If the body is to be buried, the body may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Texas</u> b. COUNTY <u>Bexar</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>San Antonio - 1</u> 80x			
c. LENGTH OF STAY IN 1b <u>1 WK</u>				d. STREET ADDRESS <u>1916 Santa Barbara St</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9815 Singleton Dr</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Nora Ellen Harwood</u>				4. DATE OF DEATH <u>Aug 7 1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-2-1879</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR <u>7</u> Months <u>7</u> Days		IF UNDER 24 HRS. <u>1958</u> Hours <u>7</u> Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Ky.</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>T.H. Colgrove</u>				14. MOTHER'S MAIDEN NAME <u>Tabitha ?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Clare Harwood -</u>			
17. INFORMANT <u>Steve 1</u>				Address <u>Steve 1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>sudden</u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>8-7-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-10-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Salem Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Albermarle, North Carolina</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Timothy Hanlon</u>				ADDRESS <u>3831-Ga. Ave. N.W.</u>		24a. REC'D BY REGISTRAR <u>AUG 11 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. Search</u>			



9259

Item 1 Film G233 : /28/CR 79

CERTIFICATE OF DEATH

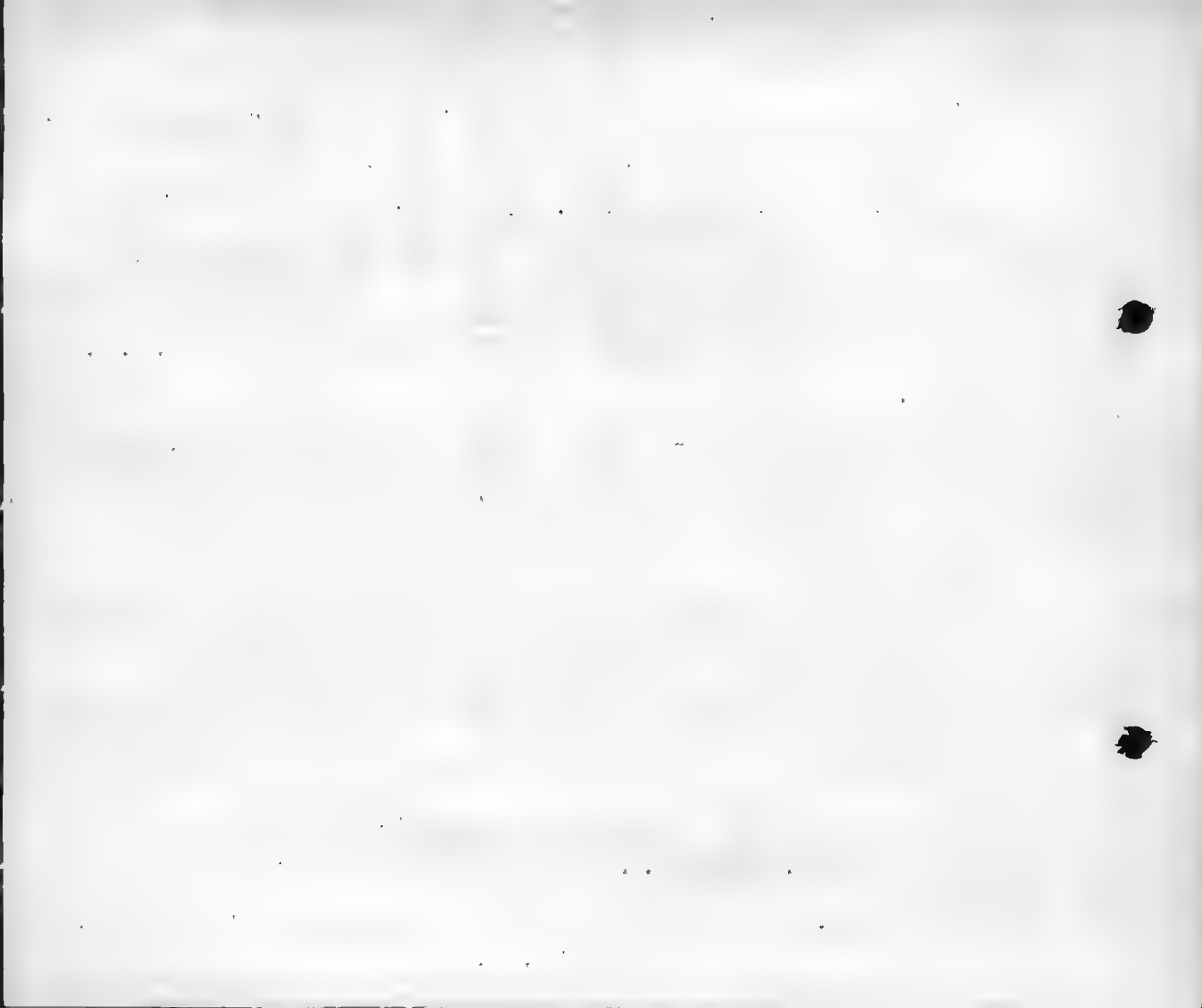
09242

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Prince Georges Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 357 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville Fairland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 6509 20th Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Harold Douglas Haynes		4. DATE OF DEATH Month Day Year August 22, 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 7, 1909	9. AGE (In years last birthday) 49 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 49
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10b. KIND OF BUSINESS OR INDUSTRY Plumbing		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Louis F. Haynes		14. MOTHER'S MAIDEN NAME Margaret Stanger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 577-07-7751		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction c ventricular fibrillation 3 minutes DUE TO (b) Hypertensive cardiovascular disease DUE TO (c) 10 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH 10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) History of cerebral thrombosis					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 9, 1957 to August 22, 1958 that I last saw the deceased alive on August 22, 1958 and that death occurred at 7:35 P.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE Alan F. Hoffmann		M.D. The Clinical Center		DATE SIGNED 8/24/58	
PHYSICIAN'S NAME (Type) Alan F. Hoffmann, M.D.		National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 27, 1958	22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Prince George's County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		ADDRESS Silver Spring, Md.		24a. REC'D BY REGISTRAR DATE AUG 26 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Kline

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9186

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b 17 Takoma Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8627 Flower Avenue		d. STREET ADDRESS 8627 Flower Avenue	
3. NAME OF DECEASED (Type or print) First CHESTER Middle E Last HEISEY		4. DATE OF DEATH Month August Day 19 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 24, 1901
9. AGE (In years last birthday) 57 yrs		10. IF UNDER 24 YEARS Months 3 Days 25 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Haberdashery		10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania	
11. BIRTHPLACE (State or foreign country) US		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Edward Heisey		14. MOTHER'S MAIDEN NAME Ella Erbb	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 265-12-7299	
17. INFORMANT Ruth P. Heisey-Item #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerosis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 10 min			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John G. Ball		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John G. Ball		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE 19 Aug 1958	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/22/58	
22c. NAME OF CEMETERY OR CREMATORY Kraybill Cem.		22d. LOCATION (City, town, or county) (State) Mt. Joy, Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		24a. REC'D BY REGISTRAR Bethesda, Maryland	
24b. REGISTRAR'S SIGNATURE AUG 21 '58		DATE 19 Aug 1958	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Pages 1, 2, and 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



9260

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9703 Cedar Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle LOUIS Last HEMLINGE		4. DATE OF DEATH Month August Day 17 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 10, 1870
9. AGE (In years last birthday) yrs. 87		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher	
11. BIRTHPLACE (State or foreign country) France		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Phillippe Helmlinge		14. MOTHER'S MAIDEN NAME Barbara Nippert	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) WW1 Reserve		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. F. Smith-daughter-same as 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Disease DUE TO (b) Atrio-Ventricular Dissociation DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Aug 16, 1958		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 13, 1958 to Aug 18, 1958 , that I last saw the deceased alive on Aug 17, 1958 , and that death occurred at 7:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1532-16th St. N. W., Wash. D. C. DATE SIGNED 8/17/58			
ACTUAL SIGNATURE Robert E. Moran Jr. M.D.			
PHYSICIAN'S NAME (Type) Robert E. Moran, Jr.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 8/22/58	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	22d. LOCATION (City, town, or county) (State) Suitland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR DATE AUG 21 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

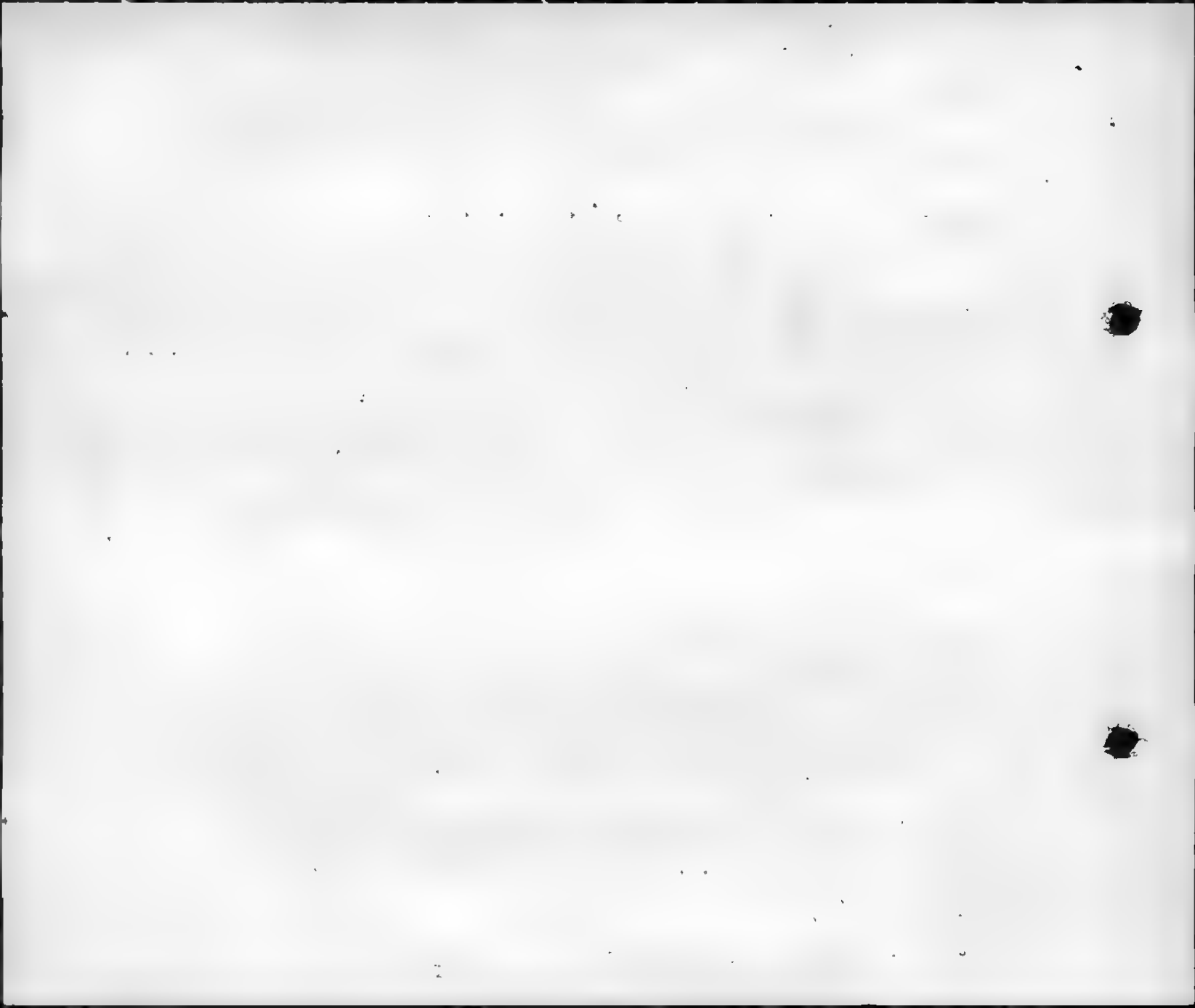
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution - Residence before admission) a. STATE Pennsylvania b. COUNTY Mont Joy	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 60 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS R. D. #2	
3. NAME OF DECEASED (Type or print) Douglas Lee Hepler		4. DATE OF DEATH Month August Day 11 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 October 1949
9. AGE (In years last birthday) yrs. 8		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Hepler		14. MOTHER'S MAIDEN NAME Anna Ruth Nolt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Lymphocytic Leukemia DUE TO (b) Acute Hemorrhagic Menstruation Colitis DUE TO (c) Generalized petechial hemorrhage		INTERVAL BETWEEN ONSET AND DEATH - 7 days - 4 days - 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 12, 1958 , to August 11, 1958 , that I last saw the deceased alive on August 11, 1958 , and that death occurred at 8:35 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Leonard Garren M.D.		ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 8/12/58	
PHYSICIAN'S NAME (Type) LEONARD GARREN, M.D.		Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/14/58	
22c. NAME OF CEMETERY OR CREMATORY Silver Spring		22d. LOCATION (City, town, or county) (State) Lancaster Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS 7557 Wisc Ave Beth Md	
24a. REC'D BY REGISTRAR AUG 14 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

VS A15 (4)
15M 10/57



9262

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE New Jersey b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 24 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 531 Liberty Street	
3. NAME OF DECEASED (Type or print) First Denise Middle Diane Last Hill		4. DATE OF DEATH Month August Day 6 Year 1958	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 15, 1955
9. AGE (In years last birthday) 2 yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Child	
11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert L. Hill		14. MOTHER'S MAIDEN NAME Dorothy Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO postoperative correction of total anomalous pulmonary venous drainage, atrial septal defect and patent ductus arteriosus DUE TO and CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 13, 1958 to August 6, 1958 that I last saw the deceased alive on August 6, 1958 , and that death occurred at 9:00A , from the causes and on the date stated above.			
ACTUAL SIGNATURE N. Perryman Collins M.D.		ADDRESS (Street, city or town, state) The Clinical Center	
PHYSICIAN'S NAME (Type) N. Perryman Collins, M. D.		DATE SIGNED 8/6/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) 8-8-58		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Orange		22d. LOCATION (City, town, or county) (State) Orange, N.J.	
23. FUNERAL DIRECTOR'S SIGNATURE Frazier's Funeral Home		ADDRESS 389 R. I. Ave. Wash. D.C.	
24a. REC'D BY REGISTRAR AUG 8 '58		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon 5. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9263

CERTIFICATE OF DEATH

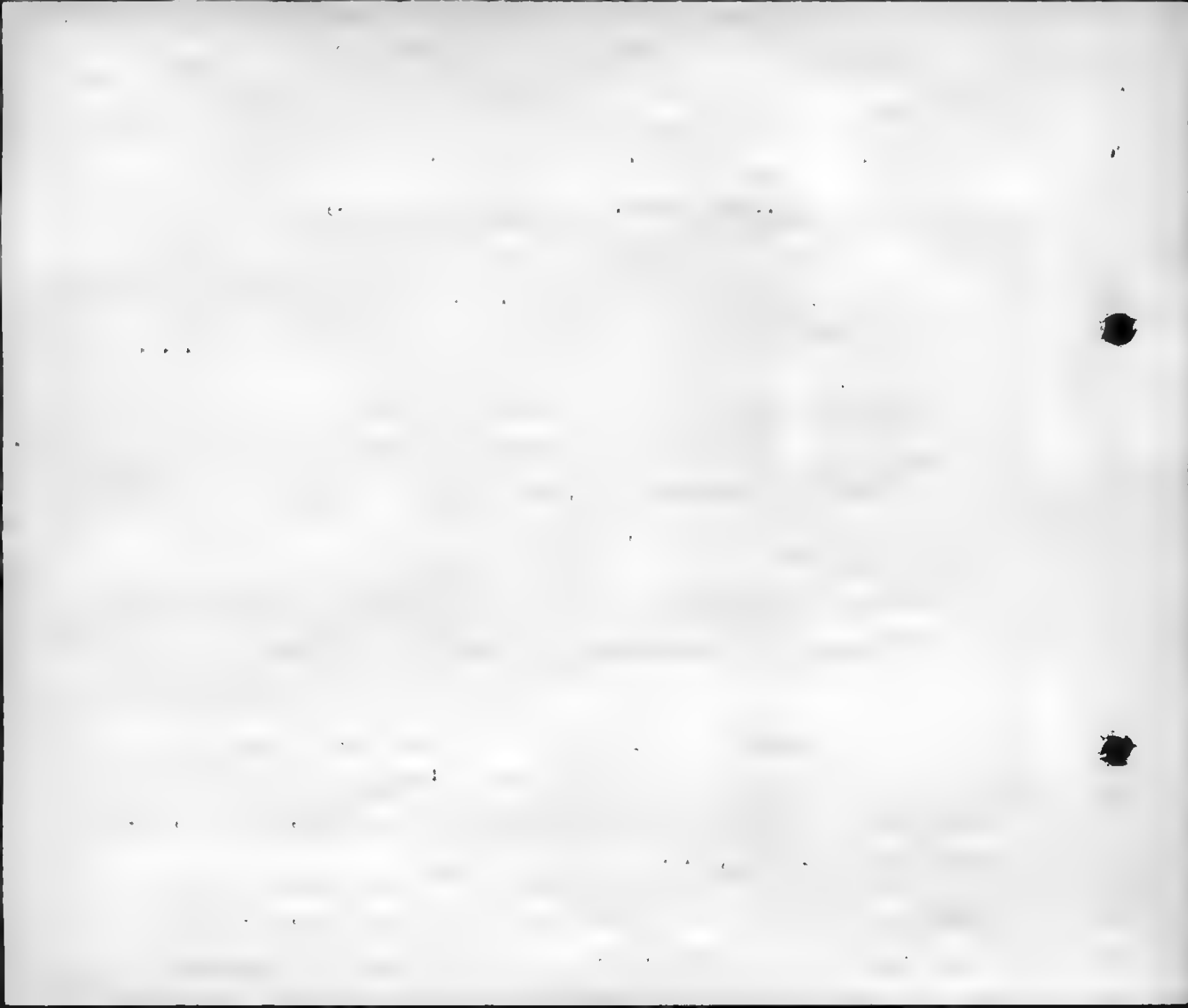
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution - Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda,				c. LENGTH OF STAY IN 1b 8 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5707 Glenwood Rd., Bethesda, Md.				e. STREET ADDRESS 5707 Glenwood Rd.,			
3. NAME OF DECEASED (Type or print) First Minnie Middle Adelia Last Hillman				4. DATE OF DEATH Month August Day 23 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 13, 1872	
9. AGE (In years) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Stowe, Vermont	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Joseph Douglas				14. MOTHER'S MAIDEN NAME Hattie Monroe			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		(If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Helen Hillman Stahl Address 5707 Glenwood Rd., Beth., Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis, abdominal 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma, stomach DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 6 months 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 14 , 19 57 , to August 23 , 19 58 , that I last saw the deceased alive on August 19 , 19 58 , and that death occurred at 4:50A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert G. Angle				ADDRESS (Street, city or town, state) 5009 Del Ray Avenue, Bethesda, Md. DATE SIGNED 8/23/58			
PHYSICIAN'S NAME (Type) Robert G. Angle, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 8/23/58		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR DATE AUG 25 58		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of this certificate and in any event within 72 hours after death, the registrar prior to burial, cremation, or removal.



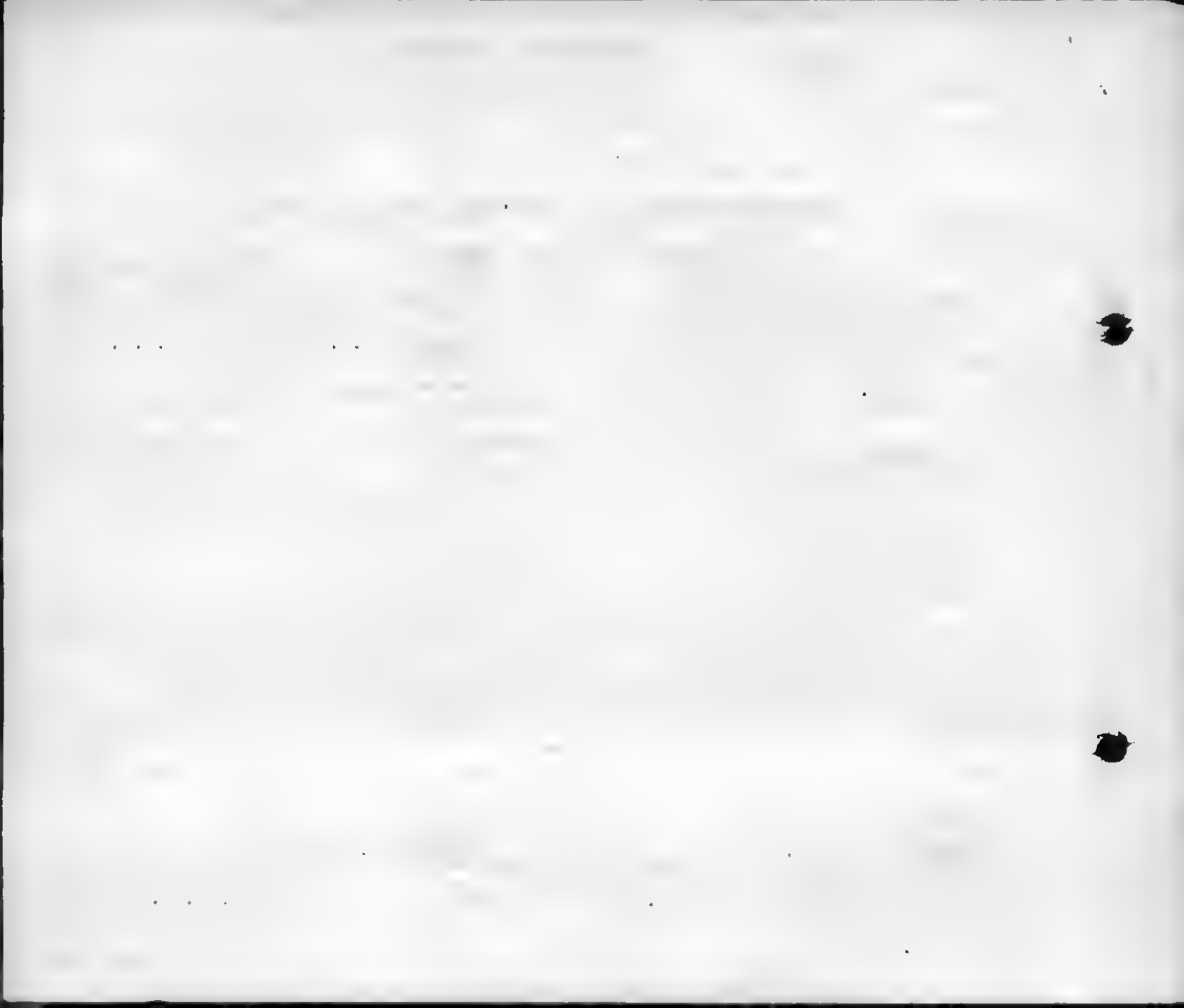
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN IB 1 hour	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
3. NAME OF DECEASED (Type or print) First Middle Last Catherine Rosalie Patricia Hines		4. DATE OF DEATH Month Day Year August 16 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 19, 1922
9. AGE (In years last birthday) 36 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 0 27	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C.	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John L. Hines		14. MOTHER'S MAIDEN NAME Catherine Rhodes	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mother Address Catherine Dwyer		As above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infectious infection DUE TO Yellow fever Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Yellow fever DUE TO Yellow fever (c) Yellow fever		INTERVAL BETWEEN ONSET AND DEATH 1 hr. 2 days Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) City diarrhea		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1, 1954 , to 8/16/58 , that I last saw the deceased alive on 8/16/58 , and that death occurred at 2:20 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rockville, Md. DATE SIGNED 8/16/58			
ACTUAL SIGNATURE Stephen N. Jones		M.D. Rockville, Maryland	
PHYSICIAN'S NAME (Type) Stephen N. Jones			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/19/48	22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Washington, D. C.
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR DATE AUG 19 58		24b. REGISTRAR'S SIGNATURE Chas E. Kraws	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is to be used as the burial-transit permit. Pages 1 and 2 should be filled with the page 3 should be detached and used as the burial-transit permit. Then please remove the page 3 and return it to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9265

CERTIFICATE OF DEATH

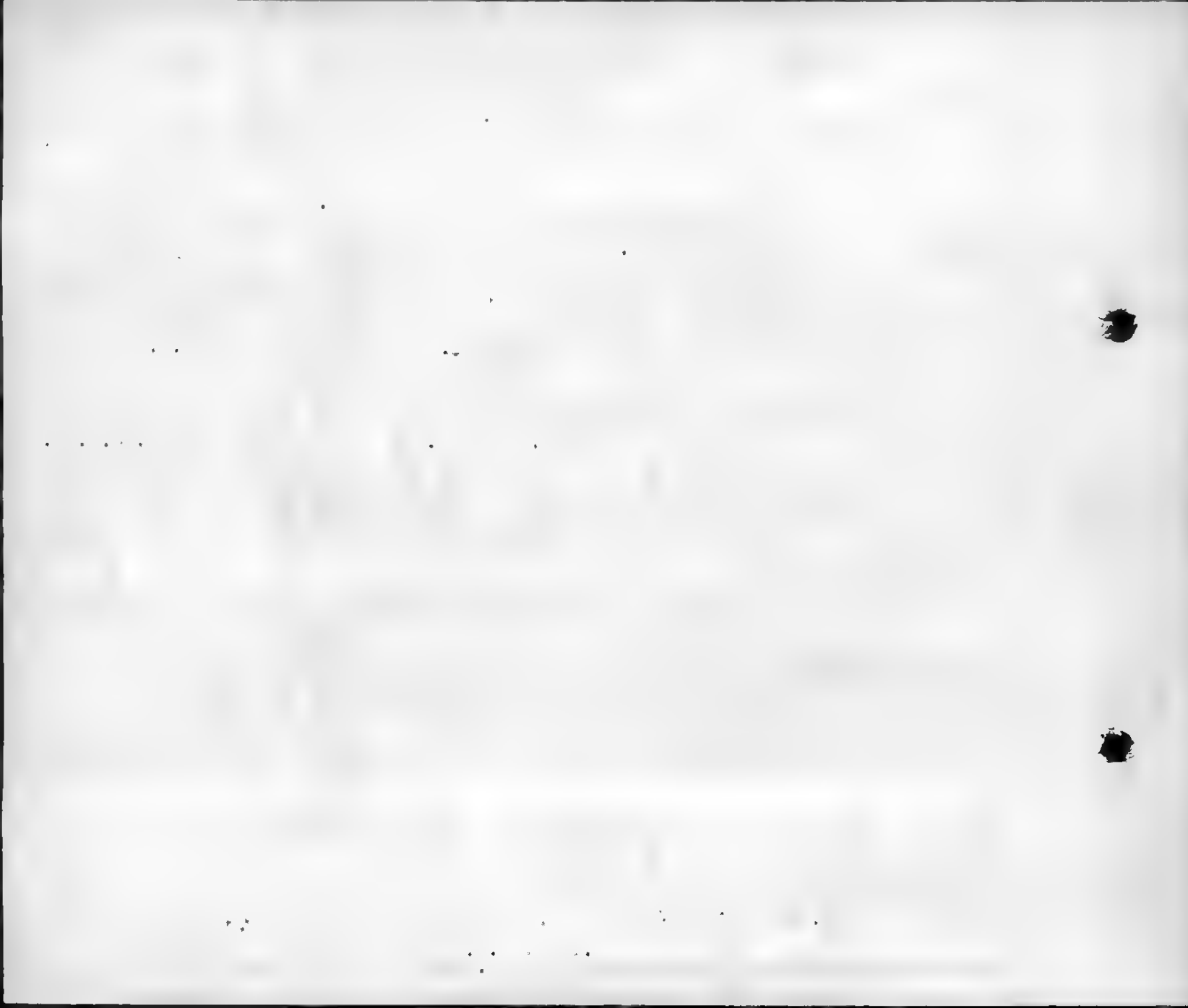
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1006 Rosemary St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Henry Thomas Buckle Moye</u>		4. DATE OF DEATH Month Day Year <u>Aug 22, 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 24, 1886</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Thomas Buckle Moye</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Lunday</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Evelyn H. Curran, 1006 Rosemary St., C.C.Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO <u>Coronary atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>Aug 8 to 22</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		(County) (State)	
21. I certify that I attended the deceased from <u>Feb. 1954</u> to <u>Aug 22 58</u> , that I last saw the deceased alive on <u>Aug 14 58</u> , and that death occurred at <u>1030</u> M, from the causes and on the date stated above.		ADDRESS (street, city or town, state)	
ACTUAL SIGNATURE <u>Geo. A. Gray, Jr.</u> M.D.		DATE SIGNED <u>Aug 27 58</u>	
PHYSICIAN'S NAME (Type) <u>Geo. A. Gray, Jr.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug 26, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Union Mt. Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Montgomery, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry E. Brown</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 27 58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

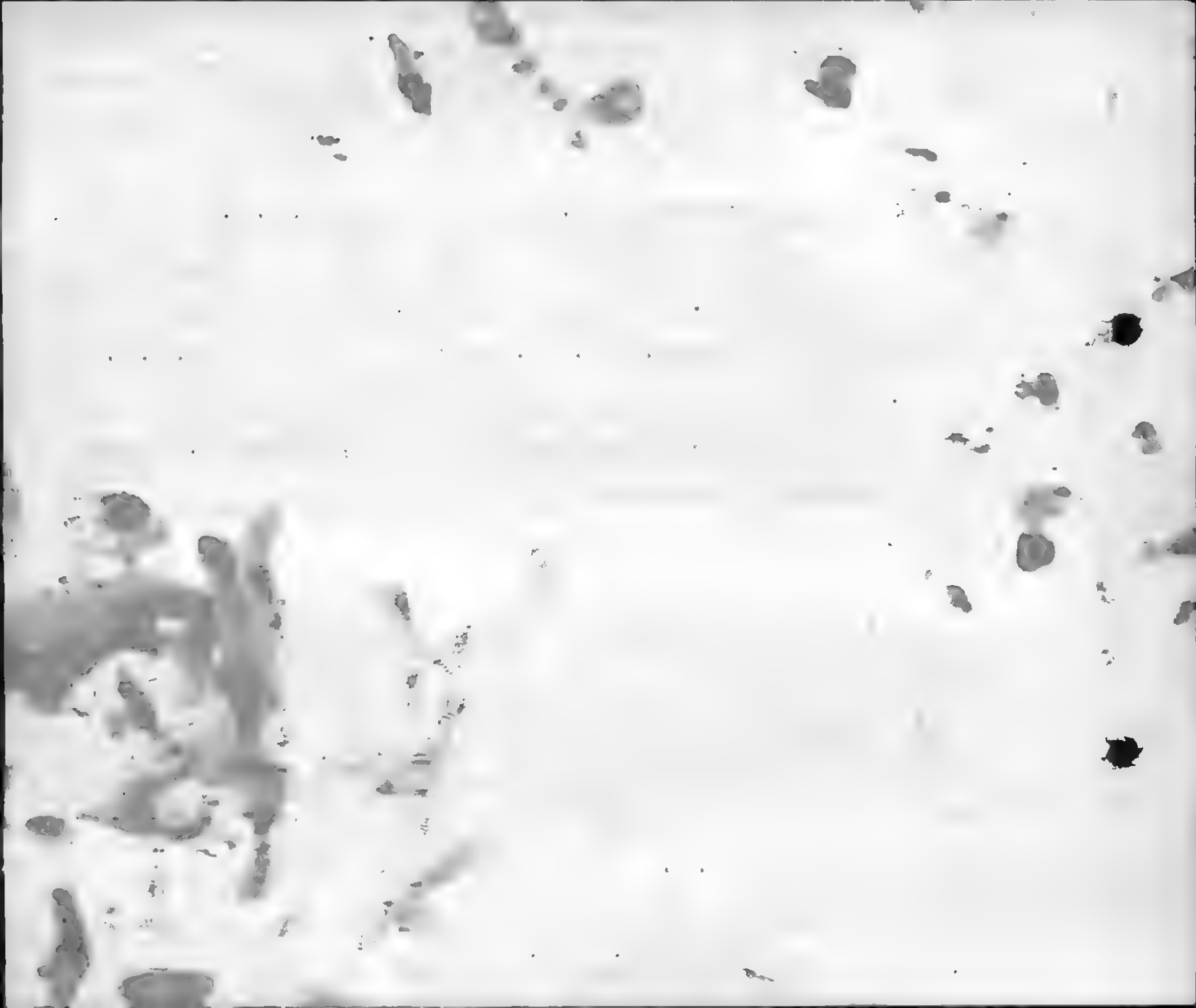
9266

CERTIFICATE OF DEATH

09250

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 80 days		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE District of Columbia b. COUNTY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		d. STREET ADDRESS 3116 Patterson Place, N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Albert Bernhardt Holtz		4. DATE OF DEATH Month August Day 17 Year 19 58		5 SEX Male		6. COLOR OR RACE White		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 7, 1917		9. AGE (In years last birthday) 41 yrs IF UNDER 1 YEAR: Months Days Hours Min IF UNDER 24 HRS: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Division Chief		10b. KIND OF BUSINESS OR INDUSTRY Internatnl. Coop. Adm.		11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13 FATHER'S NAME Albert F. Holtz		14 MOTHER'S MAIDEN NAME Mary Farley		15 WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> WW II	
16. SOCIAL SECURITY NO 309-18-8339		17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory failure DUE TO (b) Plural effusion + hypostatic pneumonia DUE TO (c) Carcinoma of Pancreas PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ? hyper emphysema		INTERVAL BETWEEN ONSET AND DEATH 2 days 3 months		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (State)		21. I certify that I attended the deceased from May 29 , 19 58 , to August 17 , 19 58 , that I last saw the deceased alive on August 17 , 19 58 , and that death occurred at 10:00 AM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 8-18-58	
ACTUAL SIGNATURE Bushnell Smith MD		PHYSICIAN'S NAME (Type) Bushnell Smith, M. D.		The National Institutes of Health Bethesda 14, Maryland		22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 8/20/1958		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gauder		ADDRESS 1756 Penna., Ave., NW		24a. REC'D BY REGISTRAR Aug 20 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hous		24c. DATE AUG 20 '58		24d. REGISTRAR'S SIGNATURE Arthur S. Hous		24e. DATE AUG 20 '58	



9267

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	c. LENGTH OF STAY IN 1b 1 day	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS 2706 Navarre Drive	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Catherine Middle Mildred Last Horn		4. DATE OF DEATH Month August Day 17 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 25, 1915
9. AGE (In years last birthday) 42 yrs		IF UNDER 1 YEAR Months 42 Days 42 Hours 42 Min 42	IF UNDER 24 HRS Months 42 Days 42 Hours 42 Min 42
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Secretarial	11. BIRTHPLACE (State or foreign country) Michigan
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Harry Lazar	
14. MOTHER'S MAIDEN NAME Lena Yudkovitz		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO 217-34-0488		17. INFORMANT The Medical Record The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 36 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Metastatic carcinoma of Breast - 3 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from August 16, 1958 , to August 17, 1958 , that I last saw the deceased alive on August 17, 1958 , and that death occurred at 7:40 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 8/18/58 ACTUAL SIGNATURE James A. Rose, M.D. PHYSICIAN'S NAME (Type) James A. Rose, M. D. National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 18, 1958	22c. NAME OF CEMETERY OR CREMATORY King David Memorial Garden	22d. LOCATION (City, town, or county) (State) Falls Church, Va.
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Danzensky & Sons		24a. REC'D BY REGISTRAR DATE AUG 19 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Hand

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9268

CERTIFICATE OF DEATH

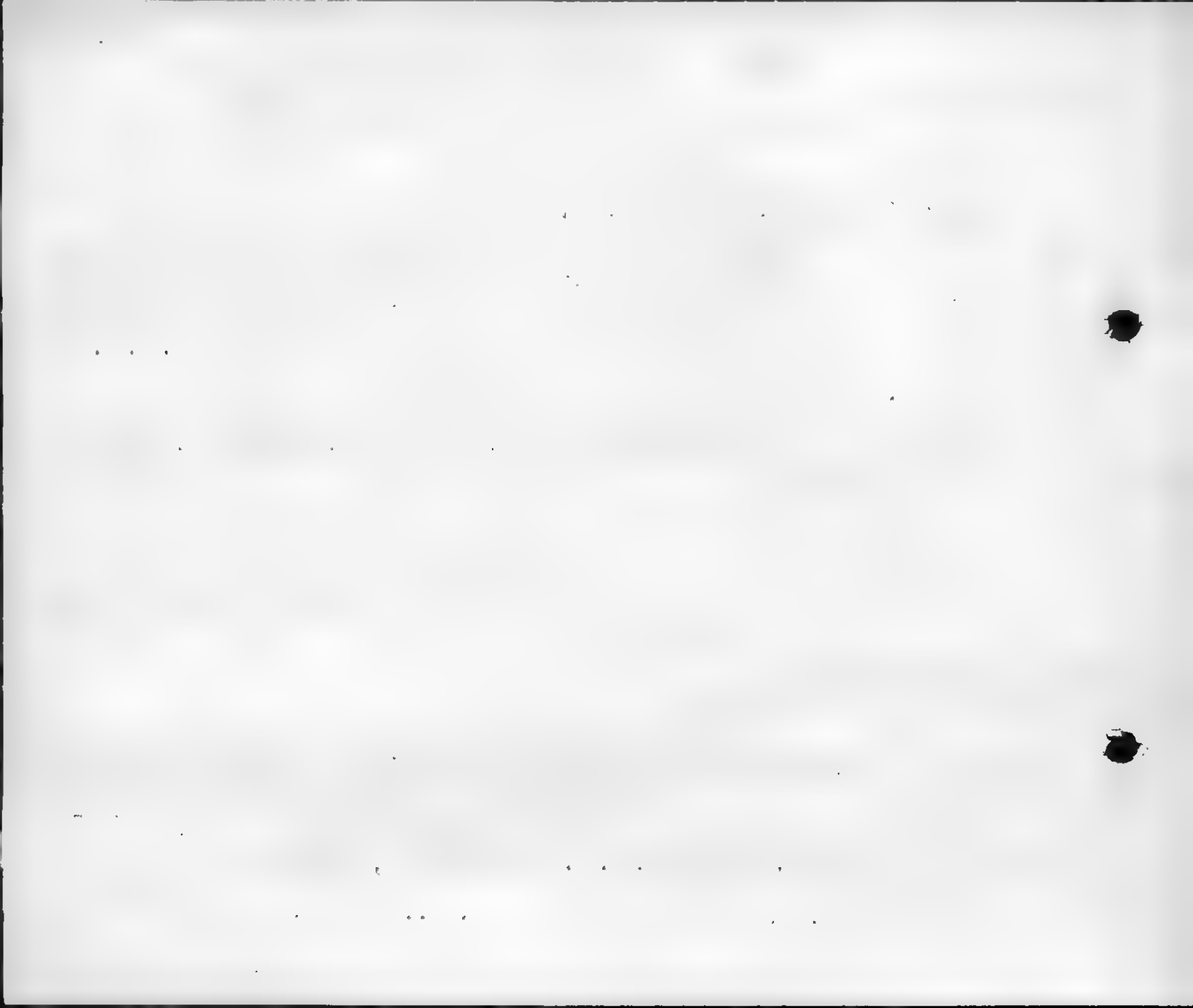
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Washington b. COUNTY 84X-3 ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 217 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.			d. STREET ADDRESS 6310 Hillcrest Drive		
3. NAME OF DECEASED (Type or print) First Jeanne Middle Alice Last Houghton			4. DATE OF DEATH Month August Day 15 Year 1958		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 13, 1939		9. AGE (In years last birthday) 19 IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington	
13. FATHER'S NAME Edwin H. Houghton			14. MOTHER'S MAIDEN NAME Loretta Dunn		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unascertainable		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 195.0 Central Nervous System Depression DUE TO Metastatic Adeno-Carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 4 yrs. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 10 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from January 10, 1958 , to August 15, 1958 , that I last saw the deceased alive on August 15, 1958 , and that death occurred at 5:35 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 8-16-58					
ACTUAL SIGNATURE Theodore L. Goodfriend		The Clinical Center National Institutes of Health Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) Theodore L. Goodfriend, M. D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF Aug. 17, 1958		22c. NAME OF CEMETERY OR CREMATORY Mountain View Mem. Cem.	
22d. LOCATION (City, town, or county) _____ (State) _____		Tacoma, Washington			
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Hawley Sons		ADDRESS 1756 Panna Avenue		24a. REC'D BY REGISTRAR AUG 19 1958	
				24b. REGISTRAR'S SIGNATURE C. L. L. L.	

MEDICAL CERTIFICATION

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9269

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b DOA		2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Spencerville		d. STREET ADDRESS En Route to Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Cecil Lambert Howes		4. DATE OF DEATH Month Day Year August 18 19 58		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/17/07		9. AGE (In years last birthday) 51 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Auto		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Samuel Howes		14. MOTHER'S MAIDEN NAME Grace		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-09-8056	
17. INFORMANT Hospital Records		Address Olney, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction, Chronic 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Sinus Tachycardia DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH 6 wks. 4 wks.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 8/1/ 19 58 , to 8/18/ 19 58 , that I last saw the deceased alive on 8/17/ 19 58 , and that death occurred at 1:15 PM , from the causes and on the date stated above.		ACTUAL SIGNATURE J. W. Bird, M. D.		M.D.		ADDRESS (Street, city or town, state) Sandy Spring, Maryland		DATE SIGNED 8/19/58							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 21, 1958		22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel		22d. LOCATION (City, town, or county) (State) Sunshine - Montgomery County Maryland									
23. FUNERAL DIRECTOR'S SIGNATURE Wayne Barber		ADDRESS Laytonville, Md.		24a. REC'D BY REGISTRAR AUG 22 '58		24b. REGISTRAR'S SIGNATURE C. L. ...									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: For use as the burial-transit permit. Then please remove carbon copy to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9270

CERTIFICATE OF DEATH

09254

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North Cherry Chase</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North Cherry Chase</u>	
c. LENGTH OF STAY IN <u>8 years</u>		d. STREET ADDRESS <u>3700 Stewart Dr. Way</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Simmons</u> Last <u>Hubbard</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>17</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/20/93</u>
9. AGE (In years last birthday) yrs. <u>65</u>		IF UNDER 1 YEAR: Months <u>5</u> Days <u>27</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Aeronautics</u>	
11. BIRTHPLACE (State or foreign country) <u>Mass</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S</u>	
13. FATHER'S NAME <u>George Hubbard</u>		14. MOTHER'S MAIDEN NAME <u>Elviny Taylor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>WW I</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>068-09-1532</u>	
17. INFORMANT <u>Mrs. Marion A. Hubbard-wife-same as 2d</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>440X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>Hypertensive cardiac vascular disease</u> (b) <u>10 years</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hours</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>None</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/13</u> 19 <u>57</u> , to <u>present</u> 19 <u>58</u> , that I last saw the deceased alive on <u>8/17/58</u> , 19 <u>58</u> , and that death occurred at <u>6:59 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8805 Conn. Ave.</u> DATE SIGNED <u>8/17/58</u>			
ACTUAL SIGNATURE <u>John B. Umhau</u> M.D.		DATE SIGNED <u>8/17/58</u>	
PHYSICIAN'S NAME (Type) <u>JOHN B. UMAU</u>		<u>Cherry Chase MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/20/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>AUG 19 1958</u>	24b. REGISTRAR'S SIGNATURE <u>Carroll S. Kneass</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9271 Item 2-3-12-13 9-3-51 et.
CERTIFICATE OF DEATH

09255

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Rockville</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Montgomery General Hospital</u>		e. STREET ADDRESS <u>806 Bryce Road</u>	
3. NAME OF DECEASED (Type or print) <u>James Thomas Hughes</u>		4. DATE OF DEATH <u>8/28/58</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/2/77</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR: Months <u>8</u> Days <u>28</u> Hours <u>19</u> Min. <u>58</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		12. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <u>William Hughes</u>		14. MOTHER'S MAIDEN NAME <u>Ann McMoran</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Spanish Am.</u>		16. SOCIAL SECURITY NO. <u>yes</u>	
17. INFORMANT <u>James T. Hughes, Jr. - Item # 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 3.0000 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Arterio-sclerosis</u> DUE TO <u>Senility</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>Grand</u> <u>Grand</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/31/58</u> to <u>8/28/58</u> , 19 <u>58</u> that I last saw the deceased alive on <u>8/28/58</u> , 19 <u>58</u> , and that death occurred at <u>11:40</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. W. Bird</u>		ADDRESS (Street, city or town, state) <u>Sandy Spring, Md.</u>	
PHYSICIAN'S NAME (Type) <u>J. W. Bird</u>		DATE SIGNED <u>8/29/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Transit</u>		22b. DATE THEREOF <u>8/29/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Emaculate Conception</u>		22d. LOCATION (City, town, or county) (State) <u>Montclair, New Jersey</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>SEP 2 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hous</u>	



9272

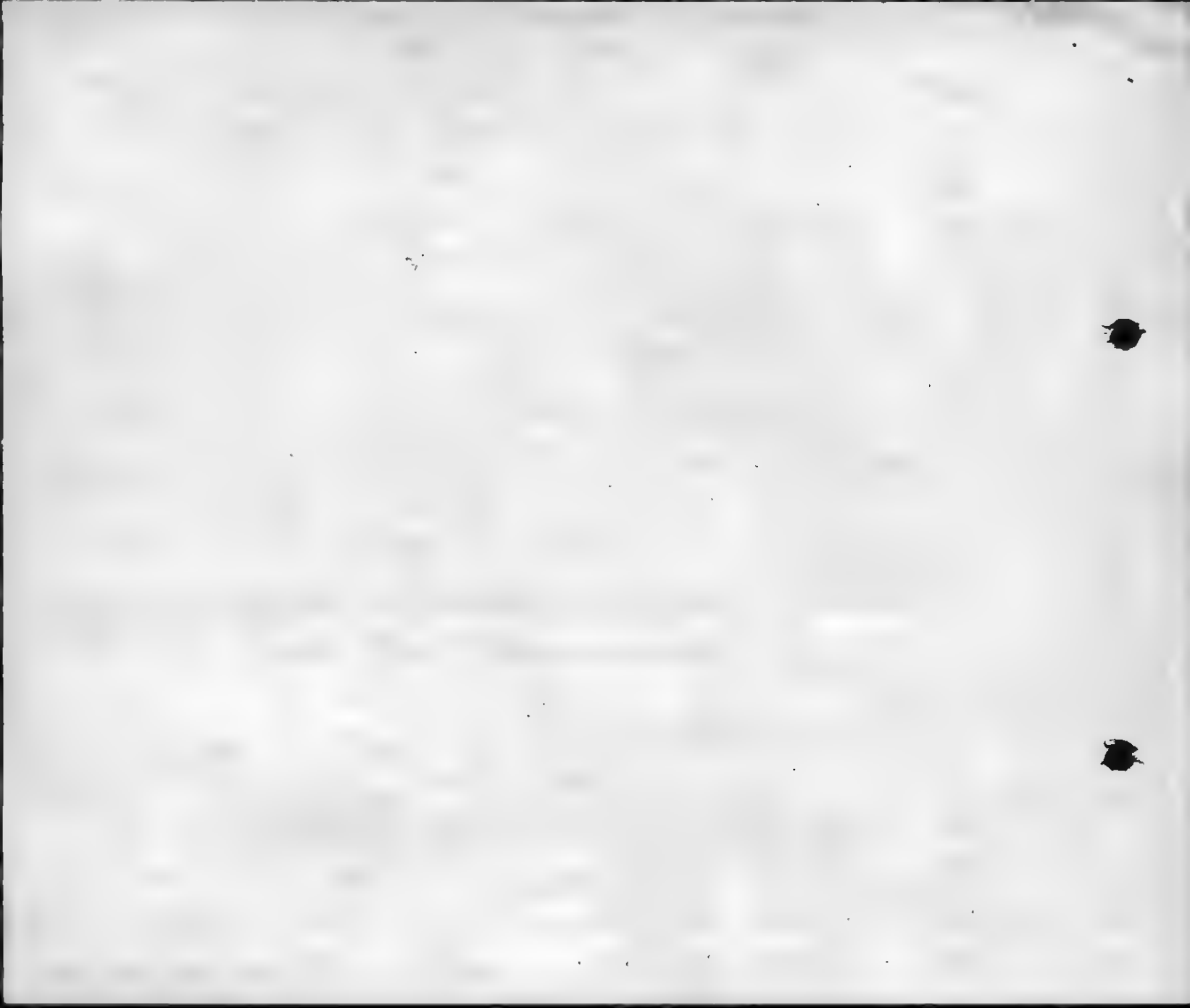
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Fairfax</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Falls Church</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>Montour Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Allen</u> Last <u>Inscow</u>		4. DATE OF DEATH Month <u>August</u> Day <u>23</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/27/1901</u>
9. AGE (In years last birthday) <u>56</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dairy</u>	
11. BIRTHPLACE (State or foreign country) <u>King George Co. - Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Austin Inscow</u>		14. MOTHER'S MAIDEN NAME <u>Nanny B. Staples</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>Pearl Inscow (Wife)</u> Address <u>see # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident</u> <u>221X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Vascular Disease</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While _____ Not while _____ at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>1920</u> to <u>date</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>August 23</u> , 19 <u>58</u> , and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John B. Ball</u>		ADDRESS (Street, city or town, state) <u>7936 Old Georgetown Rd Bethesda Md</u>	
PHYSICIAN'S NAME (Type) <u>John G. Ball</u>		DATE SIGNED <u>19</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/26/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 26 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Funa</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. Completely filled in by the attending physician and completely filled in by the funeral director, page 3 should be detached and use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9200

CERTIFICATE OF DEATH

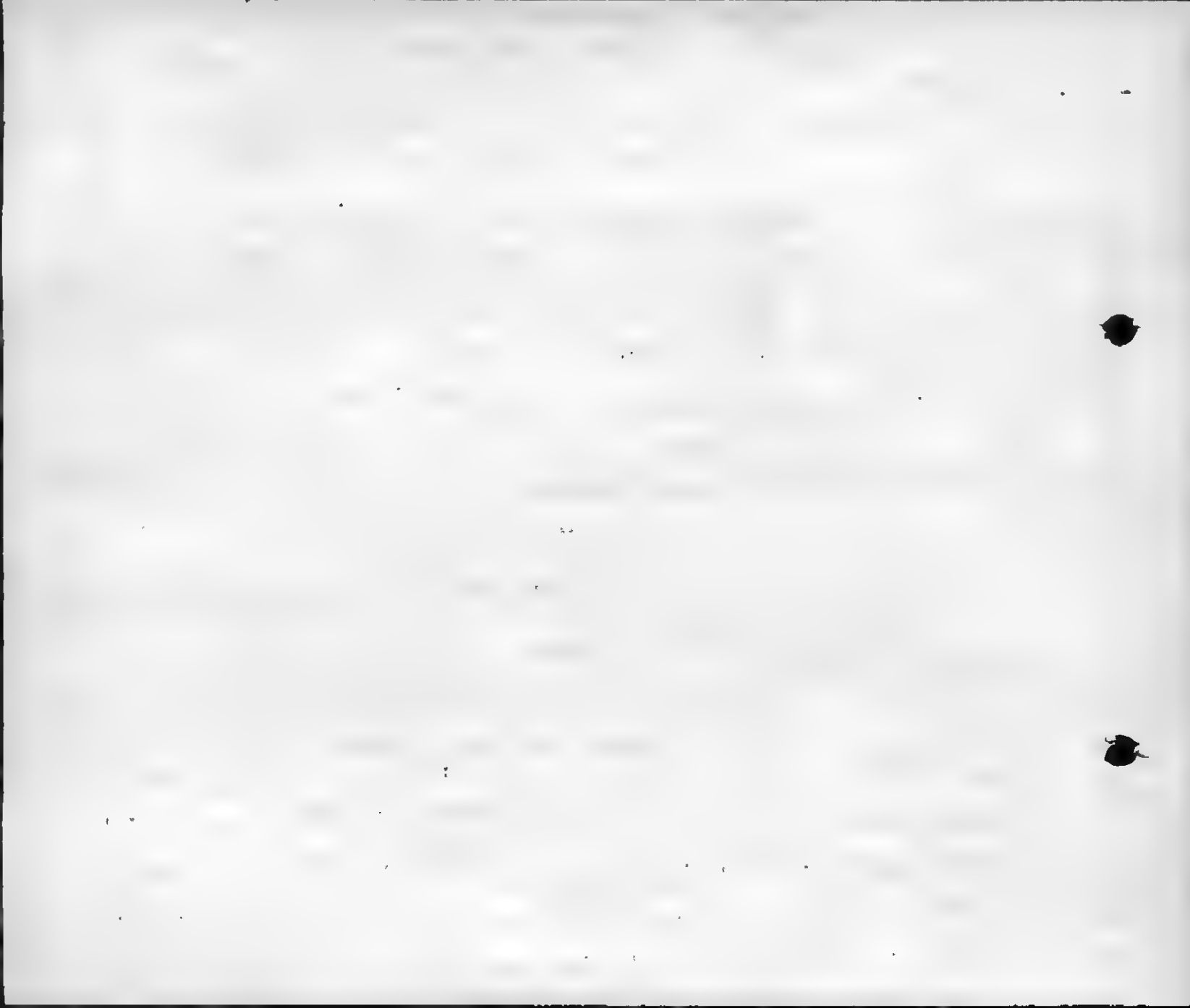
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b 5 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) Waverley Sanitarium		d. STREET ADDRESS / 4523 Middleton Lane	
3. NAME OF DECEASED (Type or print) First Middle Last Allidee IRVING		4. DATE OF DEATH Month Day Year August 14 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 27, 1886
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. 0 17	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Internal Rev.		10b. KIND OF BUSINESS OR INDUSTRY U. S. Govt.	
11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John B. Irving		14. MOTHER'S MAIDEN NAME Lillian Frazer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) Arteriosclerosis, generalized			INTERVAL BETWEEN ONSET AND DEATH 2 hours 15 years 15 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Heart Disease			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from December 30, 19 52 , to August 14, 19 58 , that I last saw the deceased alive on July 13, 19 58 , and that death occurred at 7:40 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert G. Angle		ADDRESS (Street, city or town, state) 5009 Del Ray Avenue	
PHYSICIAN'S NAME (Type) Robert G. Angle, M.D.		DATE SIGNED Aug 16, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/16/58	22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln
22d. LOCATION (City, town, or county) (State) Prince George Co., Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		24a. REC'D BY REGISTRAR DATE AUG 18 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: All of this certificate has been signed by the attending physician and is completely filled in by the funeral director. Page 3 should be detached and used as the burial-transit permit. Then please remove carbon copy of the certificate and return it to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

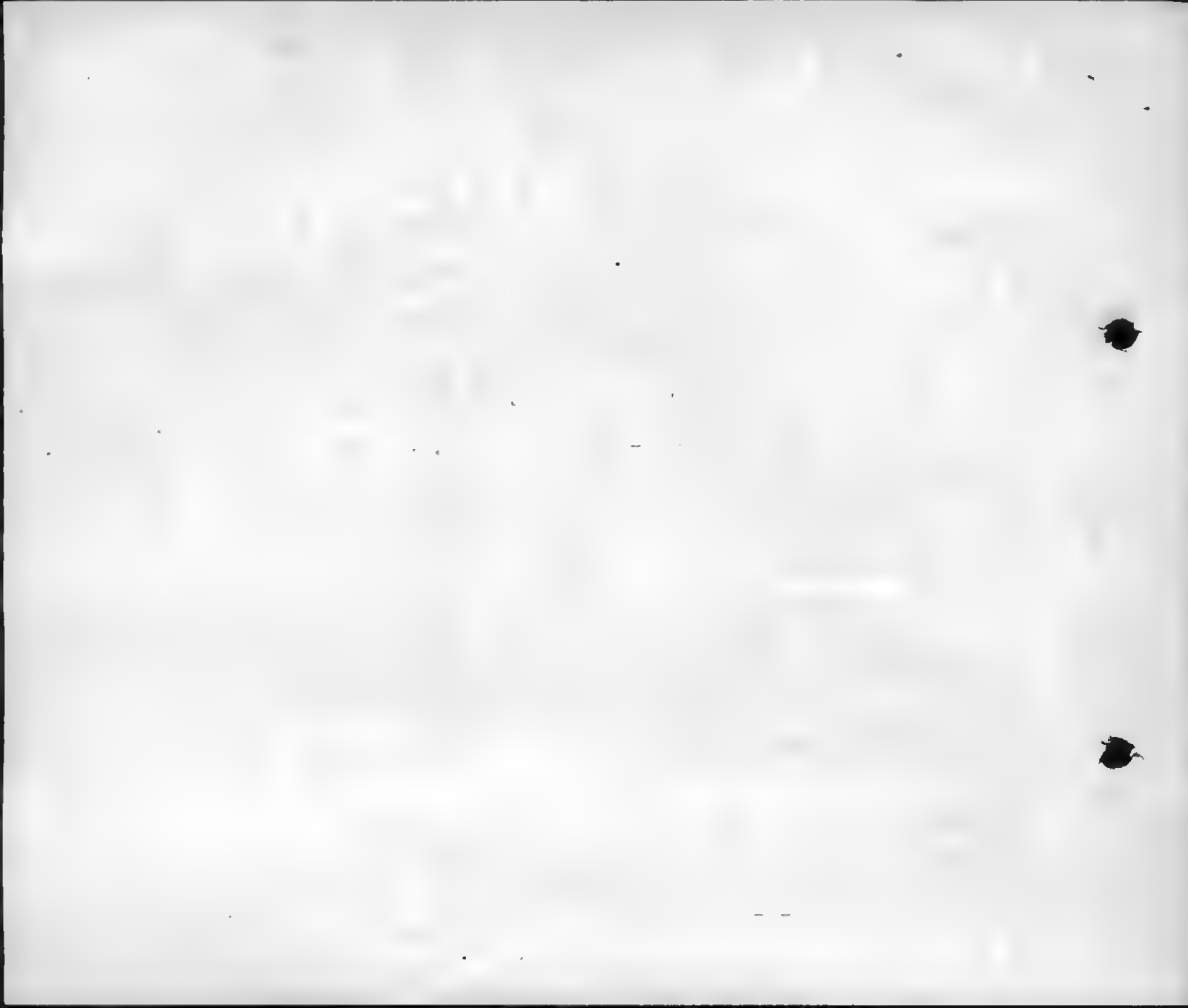
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9273 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09258

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY IN 1b <u>50 A.</u>		d. STREET ADDRESS <u>1730 Park Rd. N.W.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James M. Jeffery</u>		4. DATE OF DEATH <u>8-5-1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1895 24 August</u>
9. AGE (in years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>11</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labour</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Gardening</u>	
13. BIRTHPLACE (State or foreign country) <u>England</u>		14. CITIZEN OF WHAT COUNTRY? <u>U.S.A.G.B.</u>	
15. FATHER'S NAME <u>William Jeffery</u>		16. MOTHER'S MARRIED NAME <u>Sarah Jane Morris</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		18. SOCIAL SECURITY NO <u>045-26-9630</u>	
19. INFORMANT <u>Son</u>		Address <u>418 N. Jefferson St. Knightstown, Ind.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Collapsed while mowing lawn</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Collapsed while mowing lawn</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Brochant</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Brochant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>8-5-38</u>	
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial-Transit 8-7-58</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Glencove Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Knightstown, Indiana</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. A. Humphrey Funeral Home</u>		24a. REC'D BY REGISTRAR <u>DATE AUG 11 1958</u>	
ADDRESS <u>Bethesda, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Albrecht</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1 and 2 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



9274

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>2109 Cascade Rd</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>DAVID</u> <u>WILLIAM</u> <u>JOHNS</u>		4. DATE OF DEATH Month <u>8</u> Day <u>5</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 5 1958</u>
9. AGE (In years last birthday) <u>—</u> yrs.		IF UNDER 1 YEAR: Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>William E Johns</u>		14. MOTHER'S MAIDEN NAME <u>Meredith ANN Barton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Father - William E Johns</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis, bilateral</u> 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>fetal anoxia</u> DUE TO (c) <u>Prematurity</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8/5</u> , 19 <u>58</u> , to <u>8/5</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8/5</u> , 19 <u>58</u> , and that death occurred at <u>9:45 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Charles H. Hovest</u> M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>Aug 5-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Suburban Hosp -</u>	22d. LOCATION (City, town, or county) (State) <u>Bethesda, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home</u> ADDRESS <u>4444</u>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hovest</u>
DATE <u>AUG 21 '58</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9275

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>9 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital</u>				d. STREET ADDRESS <u>Muncaster Mill Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>C.</u> Last <u>Johnson</u>				4. DATE OF DEATH Month <u>August</u> Day <u>13</u> Year <u>19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/4/85</u>	
9. AGE (In years last birthday) <u>72</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Church Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Records</u> Address <u>Olney, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>4116 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Nephritis Interstitial</u> DUE TO (c) <u>Arterio sclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>3000</u> <u>Alcoholism</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>8/4/</u> 19 <u>58</u> , to <u>8/13/</u> 19 <u>58</u> , that I last saw the deceased alive on <u>8/12/</u> 19 <u>58</u> , and that death occurred at <u>1:00</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. W. Bird</u> M.D.				ADDRESS (Street, city or town, state) <u>Sandy Spring, Md.</u>			
DATE SIGNED <u>8/14/58</u>							
PHYSICIAN'S NAME (Type) <u>J. W. Bird, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-16-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GATES OF HEAVEN</u>		22d. LOCATION (City, town, or county) (State) <u>Aspen Hill, Mont. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. L. Snowden</u>				ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 20 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hines</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove棺盖, and in any event within 72 hours after death.



9276

CERTIFICATE OF DEATH

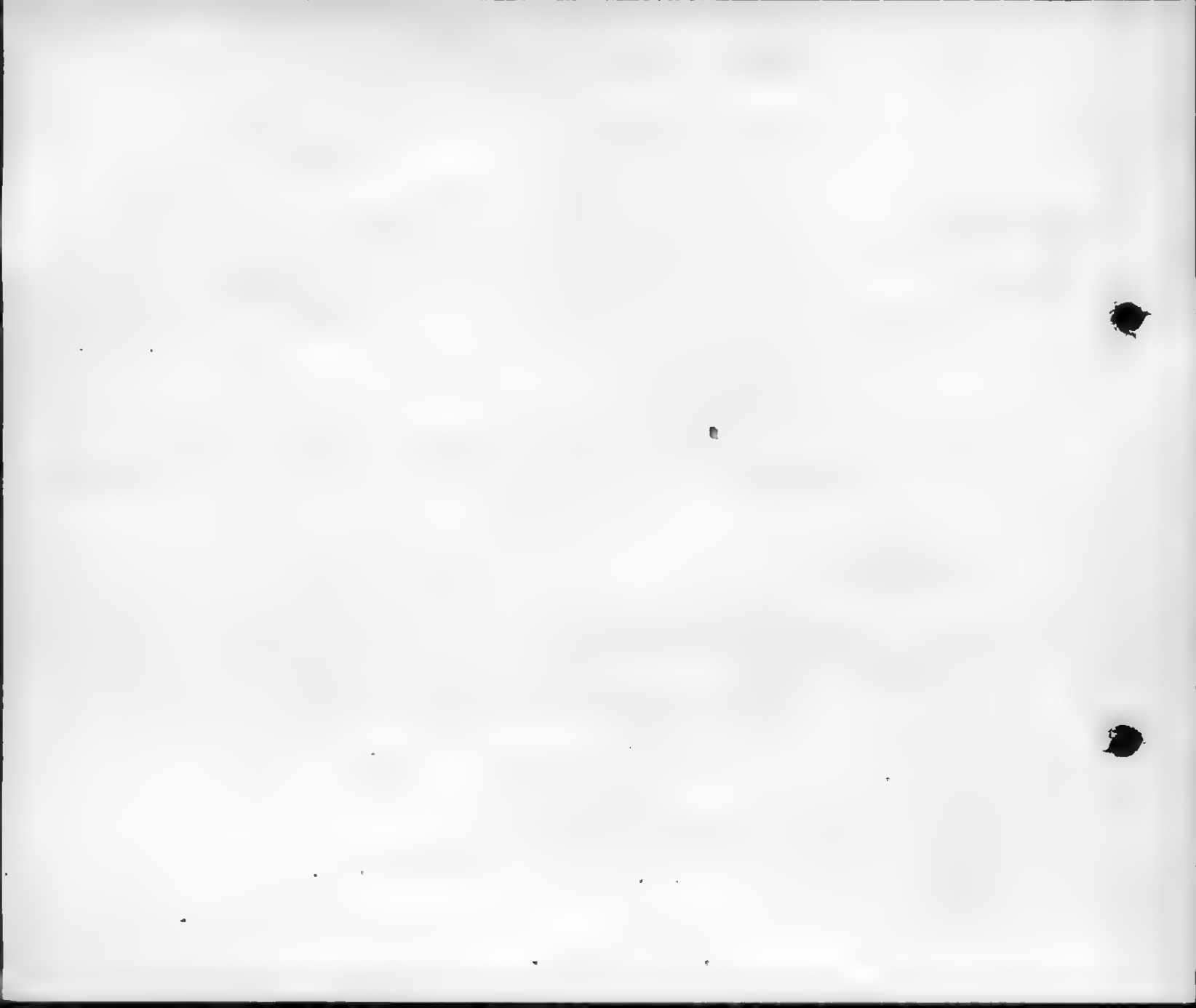
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admittance) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Highland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital, Inc.</u>		d. STREET ADDRESS <u>None</u>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>Joines</u>		4. DATE OF DEATH Month <u>August</u> Day <u>3</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 3, 1958</u>
9. AGE (In years last birthday) <u>NB</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>12</u> Days <u>12</u> Hours <u>12</u> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newborn</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Newborn</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Garyle Edison Joines</u>		14. MOTHER'S MAIDEN NAME <u>Nada R. Joines Landroth</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>hospital records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congenital atelectasis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Immaturity</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>18 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Tentorial tear, right leaf</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8.3.</u> , 19 <u>58</u> , to <u>8.3.58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8.3.58</u> , 19 <u>58</u> , and that death occurred at <u>4:20 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Charles S. Whitaker</u> M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>C. S. Whitaker, M.D.</u>		<u>Clarksville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>8/5/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Linthicum Chapel</u>	22d. LOCATION (City, town, or county) (State) <u>Clarksville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F.C. Higinbotham</u>		24a. REC'D BY REGISTRAR <u>W. L. Smith</u> DATE <u>AUG 6 '58</u>	
ADDRESS <u>Ellicott City, Md.</u>		24b. REGISTRAR'S SIGNATURE	

207-315XV2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9277

CERTIFICATE OF DEATH

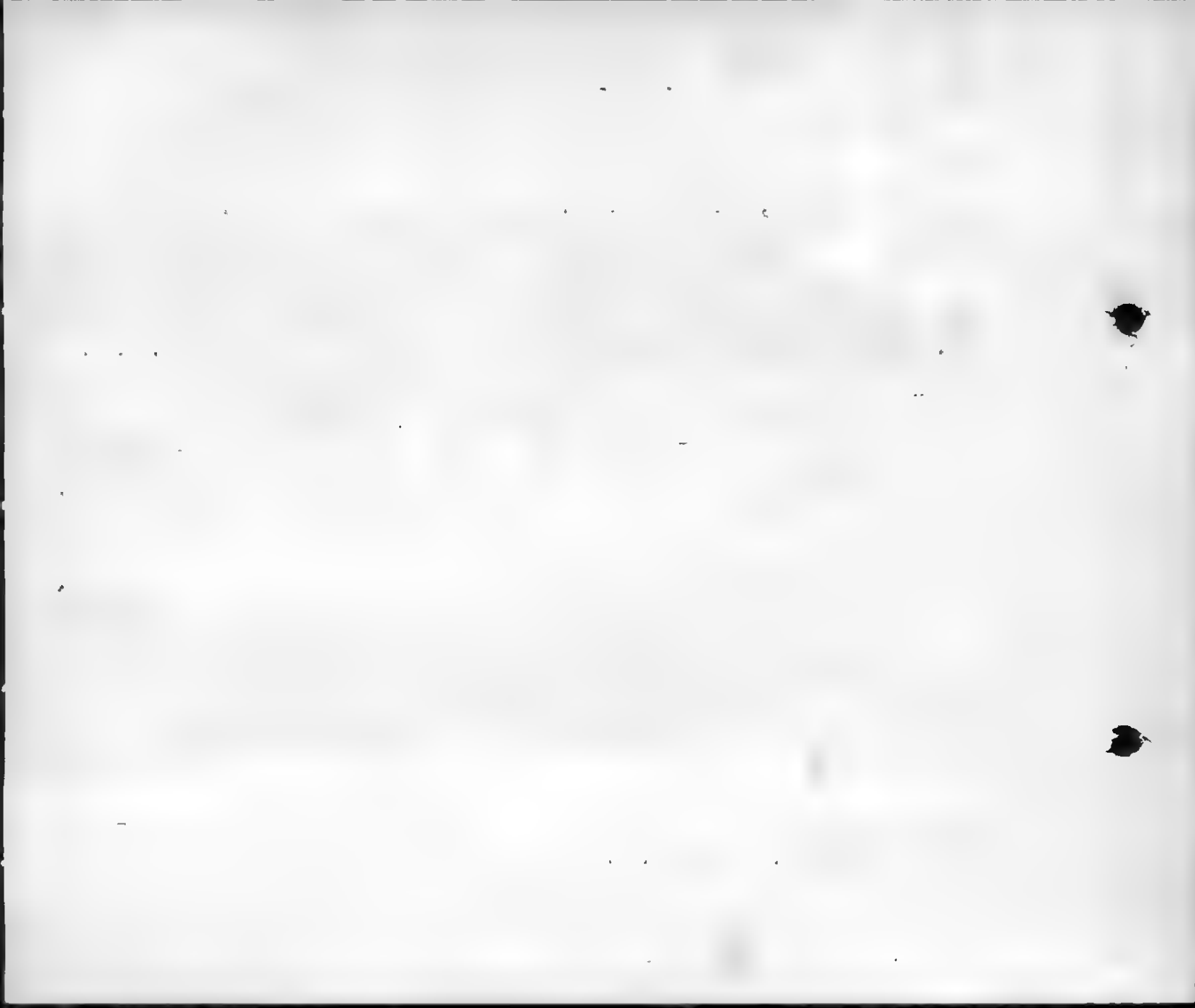
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 11 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle William Last Jones		4. DATE OF DEATH Month August Day 21 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 8, 1935
9. AGE (In years last birthday) 23		10. IF UNDER 1 YEAR: Months 7 Days 13 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Serv. Station Att't.		10b. KIND OF BUSINESS OR INDUSTRY Service Station	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Richard Howard Jones		14. MOTHER'S MAIDEN NAME Nancy Elizabeth Oden	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 577-44-8176	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO 416 X Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost (b) Pulmonary hypertension DUE TO (c) Rheumatic heart disease INTERVAL BETWEEN ONSET AND DEATH 10 min. unknown 11 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 10, 1958 to August 21, 1958 , that I last saw the deceased alive on August 21, 1958 , and that death occurred at 2:25 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 8-21-58 National Institutes of Health Bethesda 14, Maryland			
ACTUAL SIGNATURE <i>Charles P. Brooks</i> M. D.		PHYSICIAN'S NAME (Type) Charles P. Brooks, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/25/58	
22c. NAME OF CEMETERY OR CREMATORY Manassas Cemetery		22d. LOCATION (City, town, or county) (State) Manassas, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR DATE AUG 25 '58		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9278

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>D. C.</u> b. COUNTY <u>7</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 16.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>15000 River Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Beatrice</u> Middle <u>A.</u> Last <u>Joppy</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>14</u> Year <u>1958</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 1, 1900</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR: Months <u>58</u> Days <u>58</u> Hours <u>58</u> Min. <u>58</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>James Calvin Wade</u>		14. MOTHER'S MAIDEN NAME <u>Mary Jane Sidney</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Mr. William E. Smith</u>		Address <u>5000 River Road Washington 16, DC</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exsanguination</u>		<u>1 hour</u>	
DUE TO <u>Ruptured Esophageal Varices</u>		<u>12 hours</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Cirrhosis of Liver</u>		<u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1404 St.</u> , 19 <u>58</u> , to <u>1404 St.</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1 Aug. 1958</u> , and that death occurred at <u>3:10 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. J. H. Smith, M.D.</u>		DATE SIGNED <u>Aug 11, 1958</u>	
PHYSICIAN'S NAME (Type) <u>G. J. H. Smith, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/18/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park.,</u>	22d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. L. Snowden</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 20 '58</u>	
ADDRESS <u>Rockville, Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9279

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ALTHEA GLENN NURSING HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARRY Middle CHARLES Last KIMBALL		4. DATE OF DEATH Month AUGUST Day 3 Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/5/84
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk - Dept. of Defense		10b. KIND OF BUSINESS OR INDUSTRY U. S. Gov't.	
11. BIRTHPLACE (State or foreign country) New Hampshire		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles A. Kimball		14. MOTHER'S MAIDEN NAME Emma J. Colby	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO none	
17. INFORMANT Mrs. Mildred S. Kimball, 7418 Birch Ave. Takoma Park, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Generalized Arteriosclerosis (c) Generalized Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 40 min.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/12 , 19 57 , to 8/3 , 19 58 , that I last saw the deceased alive on 7/21 , 19 58 , and that death occurred at 4:30 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Dean H. Harding M.D.		ADDRESS (Street, city or town, state) 113 Carroll St NW, Wash DC DATE SIGNED 8/3/58	
PHYSICIAN'S NAME (Type) DEAN H. HARDING			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/6/58	
22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEORGES COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner B. Humphrey ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR AUG 5 58 DATE 24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, and 3 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and is to be filed in the death record. Page 3 should be detached and use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Dr Burdett, Montgomery County
Coroner, Indigent & will
approve

Deausthorpe

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon 2 and 3 and place them in the registrar's file. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9280 CERTIFICATE OF DEATH

09265

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10012 Renfrew Road		d. STREET ADDRESS 10012 Renfrew Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) GIZELLA First Middle Last KLEIN		4. DATE OF DEATH Month August Day 20 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 3, 1890
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Hungary		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Max Grun		14. MOTHER'S MAIDEN NAME Jeanette	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT William Klein		Address 10012 Renfrew Road, Silver Spring	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Arteriosclerotic Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 hours 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Recent cholecystectomy (3 weeks ago)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 55 , to August , 19 58 , that I last saw the deceased alive on 19 Aug , 19 58 , and that death occurred at 7:30 P.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Leon L. Gallin M.D.		7206 Colawville Rd	
PHYSICIAN'S NAME (Type) Leon L. Gallin M.D.		W. Hyattsville Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 22, 1958	
22c. NAME OF CEMETERY OR CREMATORY Hungarian Union Cemetery		22d. LOCATION (City, town, or county) (State) Brooklyn New York	
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Danzansky & Sons		ADDRESS 3501 14th St., N.W.	
24a. REC'D BY REGISTRAR DATE AUG 22 1958		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

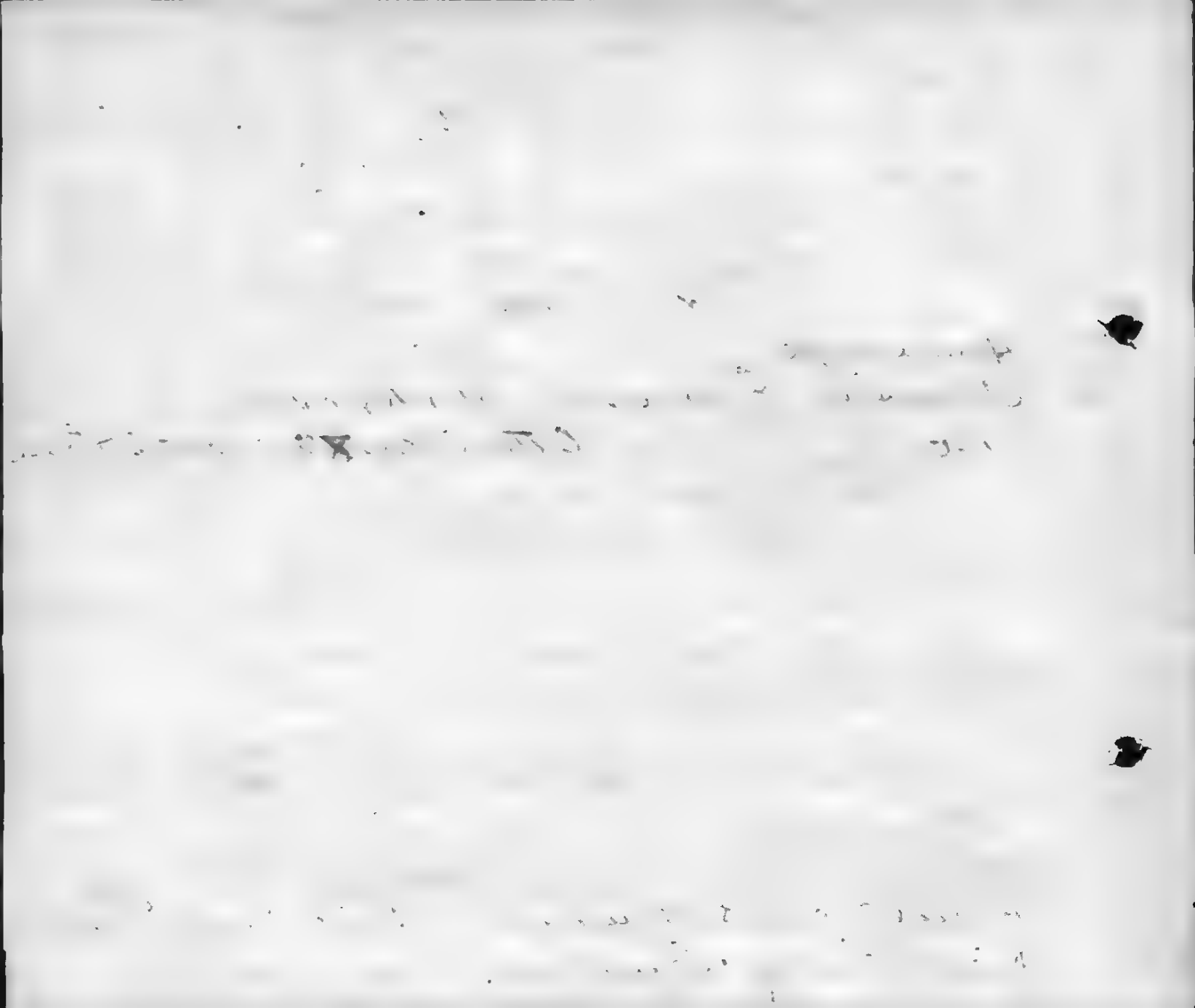
9281

CERTIFICATE OF DEATH

09266

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catheterchurch</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ammon's Rest Home</u>		d. STREET ADDRESS <u>West St</u>	
3. NAME OF DECEASED (Type or print) First <u>Marie</u> Middle <u>Knox</u> Last <u>Knox</u>		4. DATE OF DEATH Month <u>August</u> Day <u>21</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 1878</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>80</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Va</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Armstrong E. Everen</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Otto C. Knox</u>		Address <u>803 West St Laurel</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Intestinal</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Metastasis to Parotid Gland</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fractured Hip (old) may have been due to malignancy</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July Aug 1, 1958</u> to <u>Aug 21, 1958</u> , that I last saw the deceased alive on <u>August 21, 1958</u> , and that death occurred at <u>1:45 PM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Webster Sewell</u>		DATE SIGNED <u>Aug 22 1958</u>	
PHYSICIAN'S NAME (Type) <u>WEBSTER SEWELL</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Aug 23/58</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Mount Airy</u>	22d. LOCATION (City, town, or county) (State) <u>Prince George Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ridgley Selby</u>		24a. REC'D BY REGISTRAR <u>Aug 25 '58</u>	
ADDRESS <u>Laurel Md</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Hanna</u>	



9282

CERTIFICATE OF DEATH

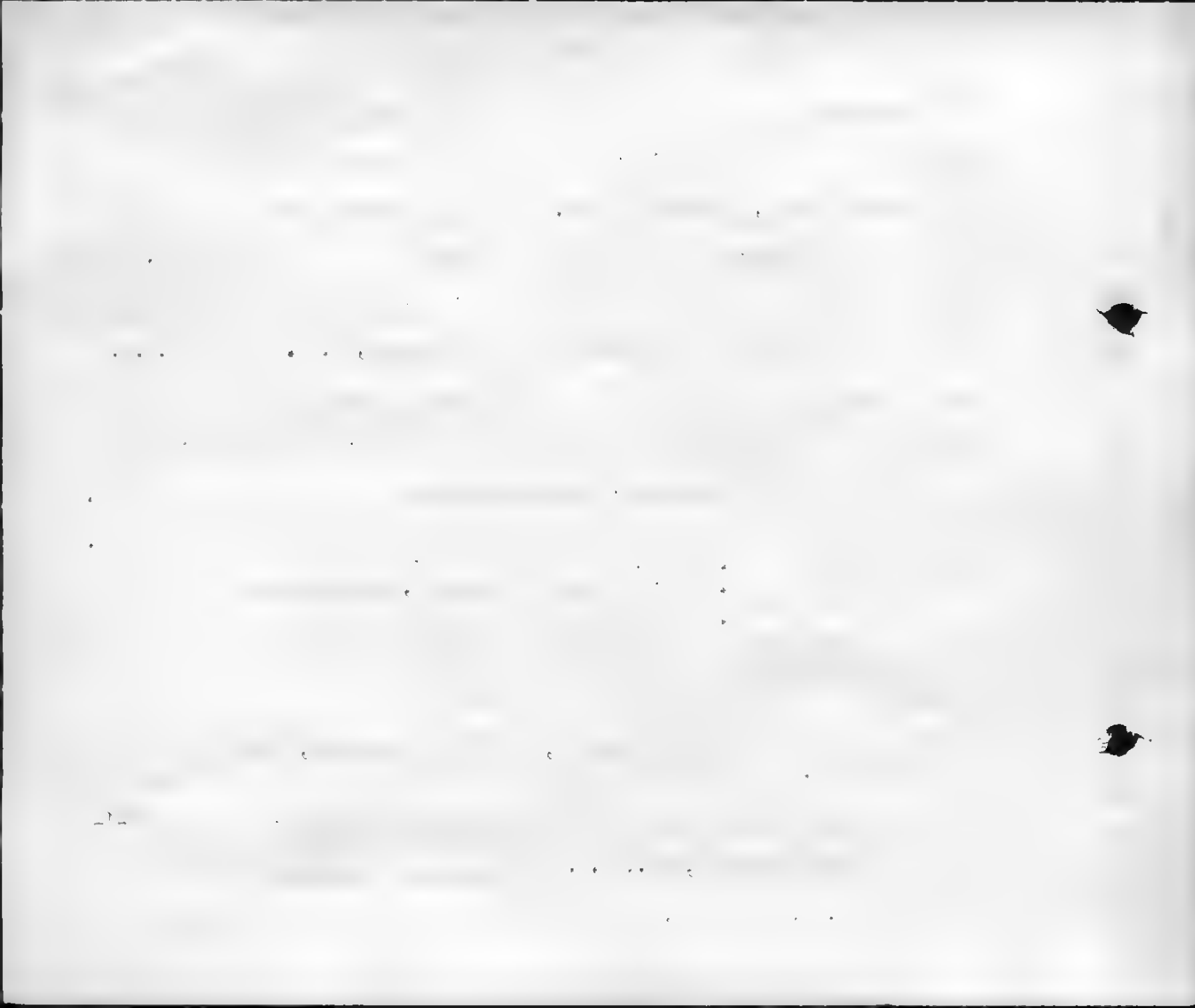
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN TB 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Roberta Middle Gail Last Konick		4. DATE OF DEATH Month August Day 6 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 17, 1957
9. AGE (In years last birthday) 8 Months 20 Days		IF UNDER 1 YEAR Hours 20 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Child	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Bernard Konick		14. MOTHER'S MAIDEN NAME Rosette Sheinbein	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hemorrhagic bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congenital heart disease DUE TO (c) 1. Patent ductus arteriosus 2. Coarctation of the aorta, infantile type PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3. Valvular pulmonic stenosis INTERVAL BETWEEN ONSET AND DEATH 8 mo. 8 mo.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from August 5, 1958 to August 6, 1958 , that I last saw the deceased alive on August 6, 1958 , and that death occurred at 12:08 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center Bethesda 14, Maryland DATE SIGNED 8-6-58			
ACTUAL SIGNATURE Louis Gillespie, Jr. M.D.		NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) Louis Gillespie, Jr., M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 7, 1958	22c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cemetery	22d. LOCATION (City, town, or county) (State) Hyattsville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Danzansky & Sons		ADDRESS 3501 14th St., N.W.	
24a. REC'D BY REGISTRAR DATE AUG 11 '58		24b. REGISTRAR'S SIGNATURE Alfred	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached and used as the burial-transit permit. Then please remove carbon page 4.



9283

CERTIFICATE OF DEATH

09268

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda, Md.</i>	
c. LENGTH OF STAY IN AB <i>13 months</i>		d. STREET ADDRESS <i>4844 Chevy Chase Drive</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>4844 Chevy Chase Drive</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Rudolph</i> Middle <i>Larsen</i> Last <i>Larsen</i>		4. DATE OF DEATH Month <i>August</i> Day <i>13</i> Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 29, 1877</i>
9. AGE (In years last birthday) <i>80 yrs.</i>		IF UNDER 1 YEAR Months <i>9</i> Days <i>24</i>	IF UNDER 24 HRS Hours <i></i> Min. <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farming</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>	
11. BIRTHPLACE (State or foreign country) <i>Nebraska</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Niels Larsen</i>		14. MOTHER'S MAIDEN NAME <i>Karen Petersen</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO <i>None</i>	
17. INFORMANT <i>Wife (Mrs. Anna Larsen)</i>		Address <i>see 2d.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cachexia (slightly progressive for 6 days)</i> DUE TO <i>acute</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>Pneumonia and heart failure</i> 6 days DUE TO <i>hyperthyroidism</i> 6 months (c) <i>Parkinsonism</i> 6 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <i>Prostate hypertrophy</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>		20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i></i>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	
20f. (City or town) (County) (State) <i></i>		21. I certify that I attended the deceased from <i>8/2</i> , 19 <i>57</i> , to <i>8/13</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>8/12</i> , 19 <i>58</i> , and that death occurred at <i>7:30 AM</i> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <i>Allen J. O'Neill</i>		ADDRESS (Street, city or town, state) <i>8601 old Beagetown Rd Bethesda Md</i>	
PHYSICIAN'S NAME (Type) <i>Allen J. O'Neill</i>		DATE SIGNED <i></i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Bur-Transit</i>	22b. DATE THEREOF <i>8/16/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Farwell Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Farwell, Nebraska</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i>		ADDRESS <i>Bethesda, Maryland</i>	
24a. REC'D BY REGISTRAR DATE <i>AUG 15 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hyatt</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Bur-

at

CERTIFICATE OF DEATH

09269

Reg. Dist. No.

9187

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>...</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY in 1b <u>2 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District of Columbia</u> ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington Sanatorium & Hospital</u>		d. STREET ADDRESS <u>2021 - 38th St., S.E.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Nettie</u> First <u>Clarissa</u> Middle <u>Lawson</u> Last		4. DATE OF DEATH <u>August 17</u> 19 <u>58</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>wh</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 21-1871</u>
9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months <u>15</u> Days <u>15</u>	IF UNDER 24 HRS Hours <u>...</u> Min. <u>...</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	11. BIRTHPLACE (State or foreign country) <u>Va.</u>
12. CITIZEN OF WHAT COUNTRY? <u>America</u>			
13. FATHER'S NAME <u>Mann Martin</u>		14. MOTHER'S MAIDEN NAME <u>Solia Nightingale</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure, acute</u> <u>1150.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis, generalized</u> (c) <u>aged</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Aug 15, 1958</u> to <u>Aug 17, 1958</u> , that I last saw the deceased alive on <u>Aug 16, 1958</u> , and that death occurred at <u>3:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. F. Thibodeau</u>		ADDRESS (Street, city or town, state) <u>10111 Colverville Rd. Silver Spring, Md.</u>	
PHYSICIAN'S NAME (Type) <u>H F THIB</u>		DATE SIGNED <u>Aug 19 58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-20-58</u>	22c. NAME OF CEMETERY OR CREMATORIUM <u>Cedar Hill</u>
22d. LOCATION (City, town or county) <u>Suitland Md.</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. F. Thibodeau</u>		ADDRESS <u>1700 1/2 7th St. N.W.</u>	
24a. REC'D BY REGISTRAR <u>Aug 19 58</u>		24b. REGISTRAR'S SIGNATURE <u>...</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon pages 1 and 2 and fill with information, or removal, and in any event within 72 hours after death.



9284

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 22 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Lewisberry c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lewisberry d. STREET ADDRESS Route 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Charles Henry Lecrone				4. DATE OF DEATH Month Day Year August 29, 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 4, 1917	
9. AGE (In years last birthday) 41 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Manager		10b. KIND OF BUSINESS OR INDUSTRY Selling		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Anthony J. Lecrone				14. MOTHER'S MAIDEN NAME Hattie A. Frey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO (If yes, give year or date of service) WW II 205-10-2847		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: 197.2 IMMEDIATE CAUSE (a) Bronchial Obstruction DUE TO Metastatic Sarcoma of the Lung (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Rhabdomyosarcoma of right Arm (c) INTERVAL BETWEEN ONSET AND DEATH 48 hours 4 months 15 months						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 7, 1958 to August 29, 1958 , that I last saw the deceased alive on August 29, 1958 , and that death occurred at 5:50 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland DATE SIGNED 8/29/58							
ACTUAL SIGNATURE Nathan S. Taylor		M.D. NATHAN S. TAYLOR, M. D.					
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		8/31/58		Mt Zion Cemetery		Springettsbury Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumpfrey				ADDRESS 7557 Wisc Ave Beth Md		24a. REC'D BY REGISTRAR DATE SEP 2 1958	
				24b. REGISTRAR'S SIGNATURE Charles S. House			

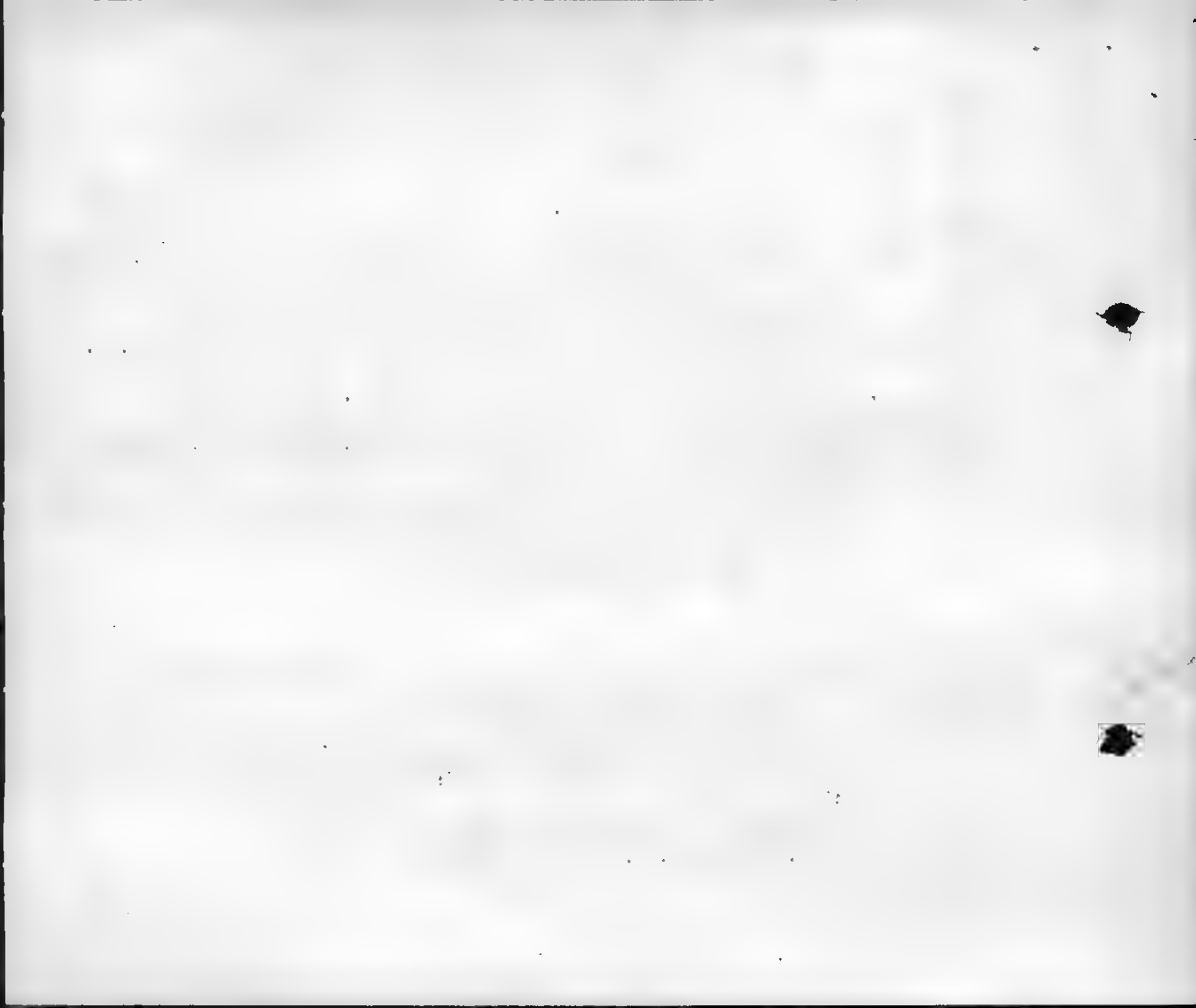
MEDICAL CERTIFICATION

2

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9285

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 39 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Warren Middle Clark Last Leffingwell				4. DATE OF DEATH Month August Day 25 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 7, 1866	
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months 91 Days 91 Hours 91 Min 91		IF UNDER 24 HRS. Months 91 Days 91 Hours 91 Min 91			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Vermont		11. BIRTHPLACE (State or foreign country) America	
13. FATHER'S NAME Dyar Leffingwell				14. MOTHER'S MAIDEN NAME Mary Jane Saunders			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT Thomas Cullen Leffingwell				Address 4011 Spruell Drive Kensington, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) unknown DUE TO (c) unknown						INTERVAL BETWEEN ONSET AND DEATH 2 Weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congestive Heart Failure						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 8-4 , 19 58 , to Aug 25 , 19 58 , that I last saw the deceased alive on Aug 24 , 19 58 , and that death occurred at 7:00 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10511 Summit Ave Kensington, Md. DATE SIGNED 8/25/58							
ACTUAL SIGNATURE George Sharpe				M.D. 10511 Summit Ave Kensington, Md.			
PHYSICIAN'S NAME (Type) George Sharpe							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 8/25/58		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR AUG 26 1958		24b. REGISTRAR'S SIGNATURE Charles P. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8 & 9, Film G-233 0, 36, 58, CAC.

CERTIFICATE OF DEATH

Reg. Dist. No.

09272

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>Silver Springs</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Silver Springs</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u>				c. LENGTH OF STAY IN TB <u>3 1/2 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8716 Leonard Drive</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Anthony</u> Last <u>LIVINGSTON</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>3</u> Year <u>1955</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1881</u> <u>Oct. 27, 1879</u>	
9. AGE (In years last birthday) <u>74</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Lithuania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis Livingston</u>				14. MOTHER'S MAIDEN NAME <u>Sarah ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <input type="checkbox"/>				16. SOCIAL SECURITY NO. <u>Ms. Sadie Livingston - Same</u>		17. INFORMANT <u>Ms. Sadie Livingston - Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>74 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1954</u> , to <u>Present</u> , that I last saw the deceased alive on <u>Aug 2</u> , 19 <u>55</u> , and that death occurred at <u>8:30 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>James A. Gordon</u>				M.D. <u>2025 - Comm. Exp. 4/1/56</u>			
PHYSICIAN'S NAME (Type) <u>A.B. GORDON</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/5/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Belmont-Burial</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Gordon</u>				ADDRESS <u>1124-26 W. North Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 5 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. L. Beach</u>			



9287

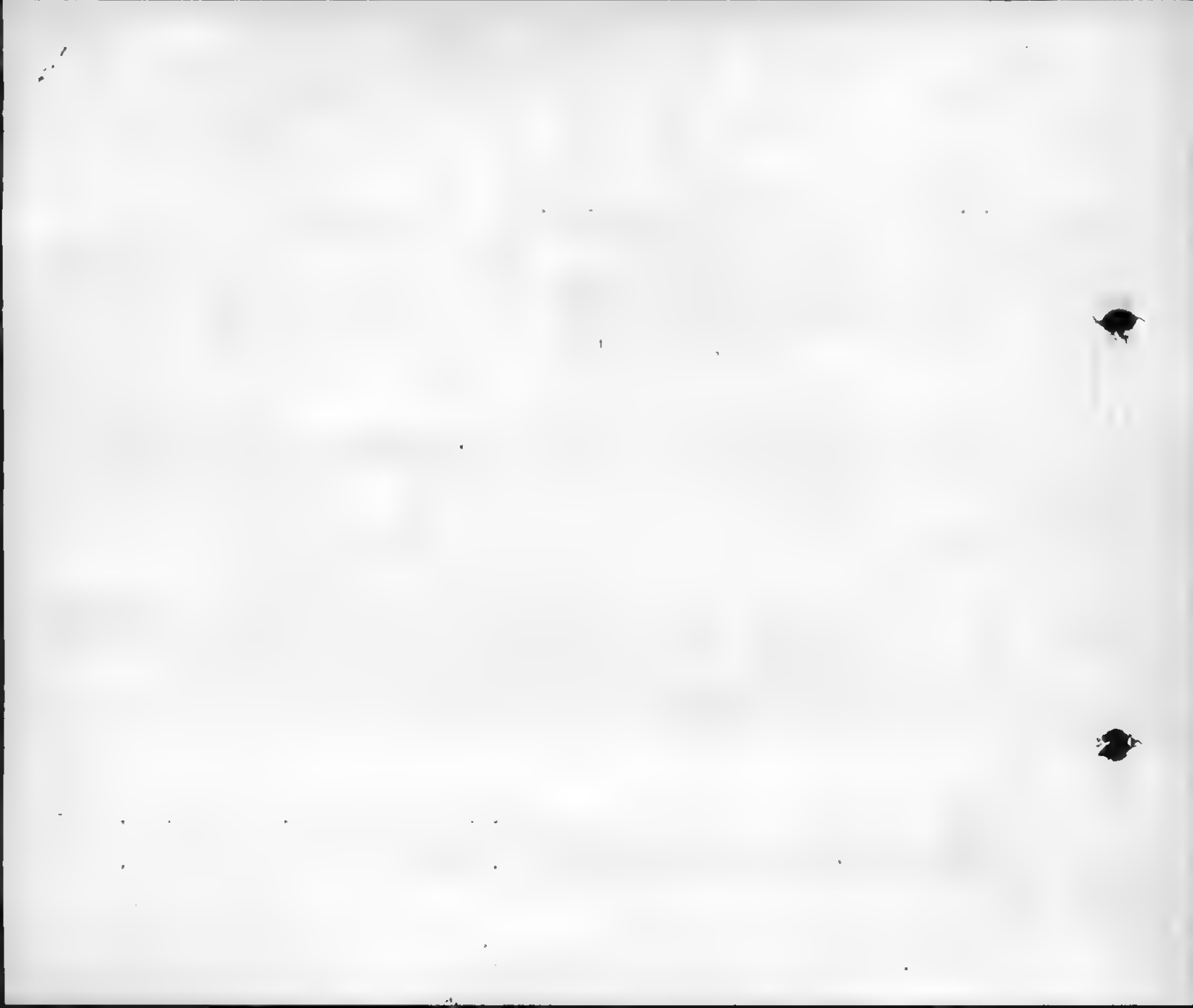
CERTIFICATE OF DEATH

Reg. Dist. No. 215

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE North Carolina b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 60 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, NMMC, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Donald Middle Wood Last LOOMIS				4. DATE OF DEATH Month August Day 4 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 15 July 1895	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy (Retired)		11. BIRTHPLACE (State or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Fred Wood LOOMIS				14. MOTHER'S MAIDEN NAME Jane GOSS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW-I and WW-II		16. SOCIAL SECURITY NO. WW-I and WW-II		17. INFORMANT (Wife) Mrs. Esther Y. LOOMIS (Same as #2)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic Carcinoma DUE TO (c) Carcinoma Lung						INTERVAL BETWEEN ONSET AND DEATH 3 days 18 mos. 18 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 471X							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5 June , 19 58 , to 4 August , 19 58 , that I last saw the deceased alive on 4 August , 19 58 , and that death occurred at 1:30 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE T. S. DUNN, JR.				ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md.			
PHYSICIAN'S NAME (Type) T. S. DUNN, JR. LT MC USN				DATE SIGNED 8-4-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6 August 1958		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Md. 7557 Wisconsin Ave.		24a. REC'D BY REGISTRAR AUG 6 '58	
				24b. REGISTRAR'S SIGNATURE W. S. Leach			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.



9188

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY in 1b <u>12 days</u>		d. STREET ADDRESS <u>105 E. Franklin Ave.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ovide</u> First <u>Arthur</u> Middle <u>Lussier</u> Last		4. DATE OF DEATH <u>August 11</u> 19 <u>58</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-9-00</u>
9. AGE (In years last birthday) <u>57</u> yrs		IF UNDER 1 YEAR	IF UNDER 24 HRS
		Months <u>8</u> Days <u>2</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk Typist, Nat'l. Institute of Health</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rhode Island</u>	
11. BIRTHPLACE (State or foreign country) <u>America</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Joseph E. Lussier</u>		14. MOTHER'S MAIDEN NAME <u>Nadeau</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-10-9006</u>	
17. INFORMANT <u>Hospital Records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute peritonitis</u> <u>12.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Massive retro peritoneal abscess right side</u> DUE TO (c) <u>Diverticulitis right colon</u>			<u>24 hrs.</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 52</u> to <u>Aug 11</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Aug 11</u> , 19 <u>58</u> , and that death occurred at <u>11 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bernard A. Fitzgerald</u> M.D.		ADDRESS (Street, city or town, state) <u>207 University Blvd E. S.S.</u> DATE SIGNED <u>8-11-58</u>	
PHYSICIAN'S NAME (Type) <u>BERNARD A. FITZGERALD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>8/14/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>UNION CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>BURTONSVILLE, MONTGOMERY CO., MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner C. Humphrey</u> ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>AUG 14 '58</u>	24b. REGISTRAR'S SIGNATURE <u>O. L. H. H.</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and filed with the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Pages 1, 2, and 3 should be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH-DEPT.

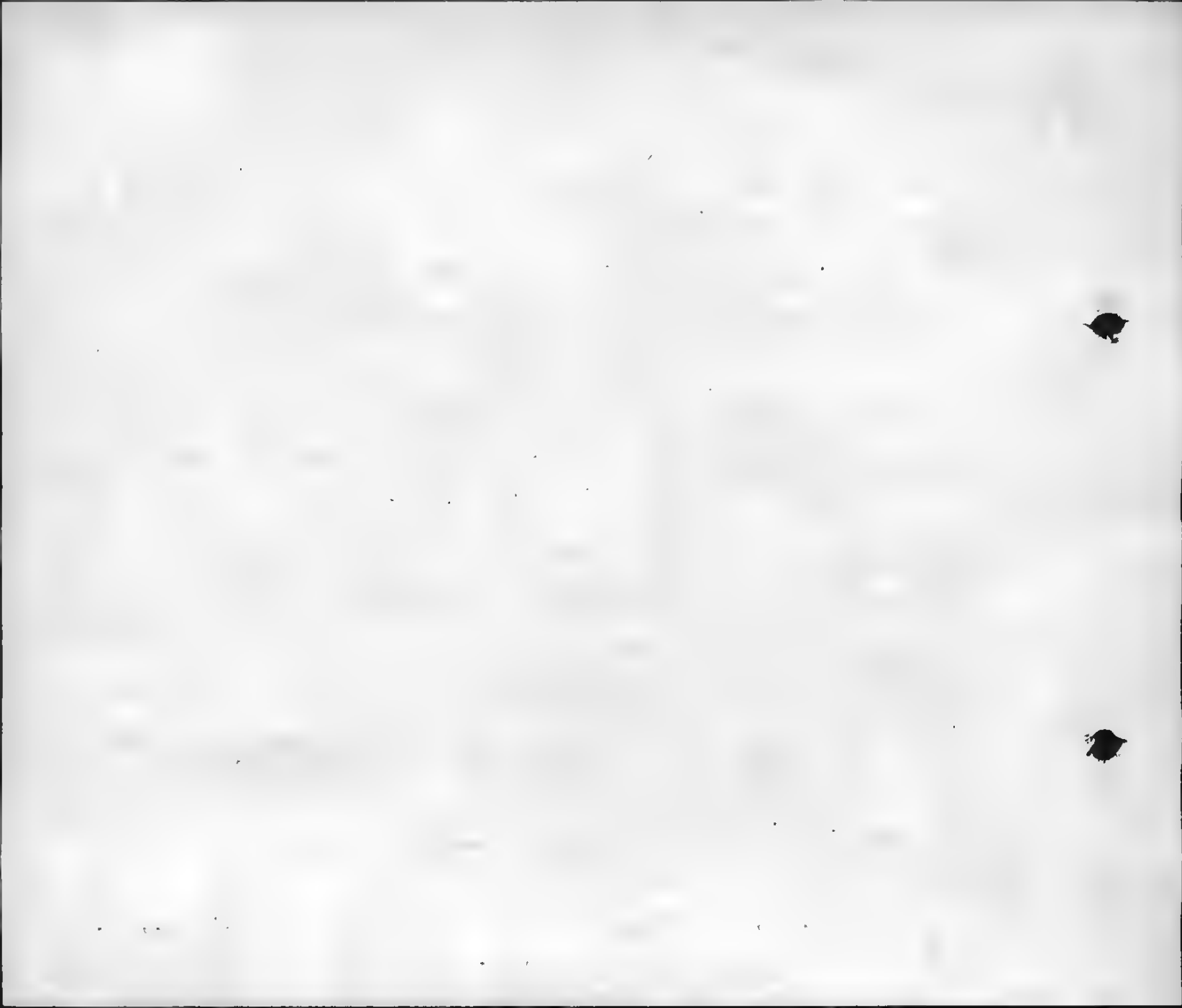
MS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9288 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09275

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>20 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9000 Flower Ave</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
3. NAME OF DECEASED (Type or print) <u>William Oscar Marks</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>25</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-26-1899</u>
9. AGE (in years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR Months <u>25</u> Days <u>5</u> Hours <u>19</u> Min <u>58</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>	
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Samuel Marks</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>none</u>	
17. INFORMANT <u>Frederick J. Sellers</u>		Address <u>Stem 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Bullet wound Thrombosis hemorrhage</u> (c) <u>stating the underlying cause last.</u> DUE TO (c) <u>Middle</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Self-inflicted bullet wound Thrombosis hemorrhage</u>	
20c. TIME OF INJURY Month <u>Aug</u> Day <u>25</u> Year <u>1958</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <u>at work</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) <u>Silver Spring</u> (County) <u>Montg</u> (State) <u>md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>8-25-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 27, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) <u>Prince George's Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner C. Pumphrey</u>		ADDRESS <u>Silver Spring, Md.</u>	
24a. REC'D BY REGISTRAR <u>AUG 27 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	



9289

CERTIFICATE OF DEATH

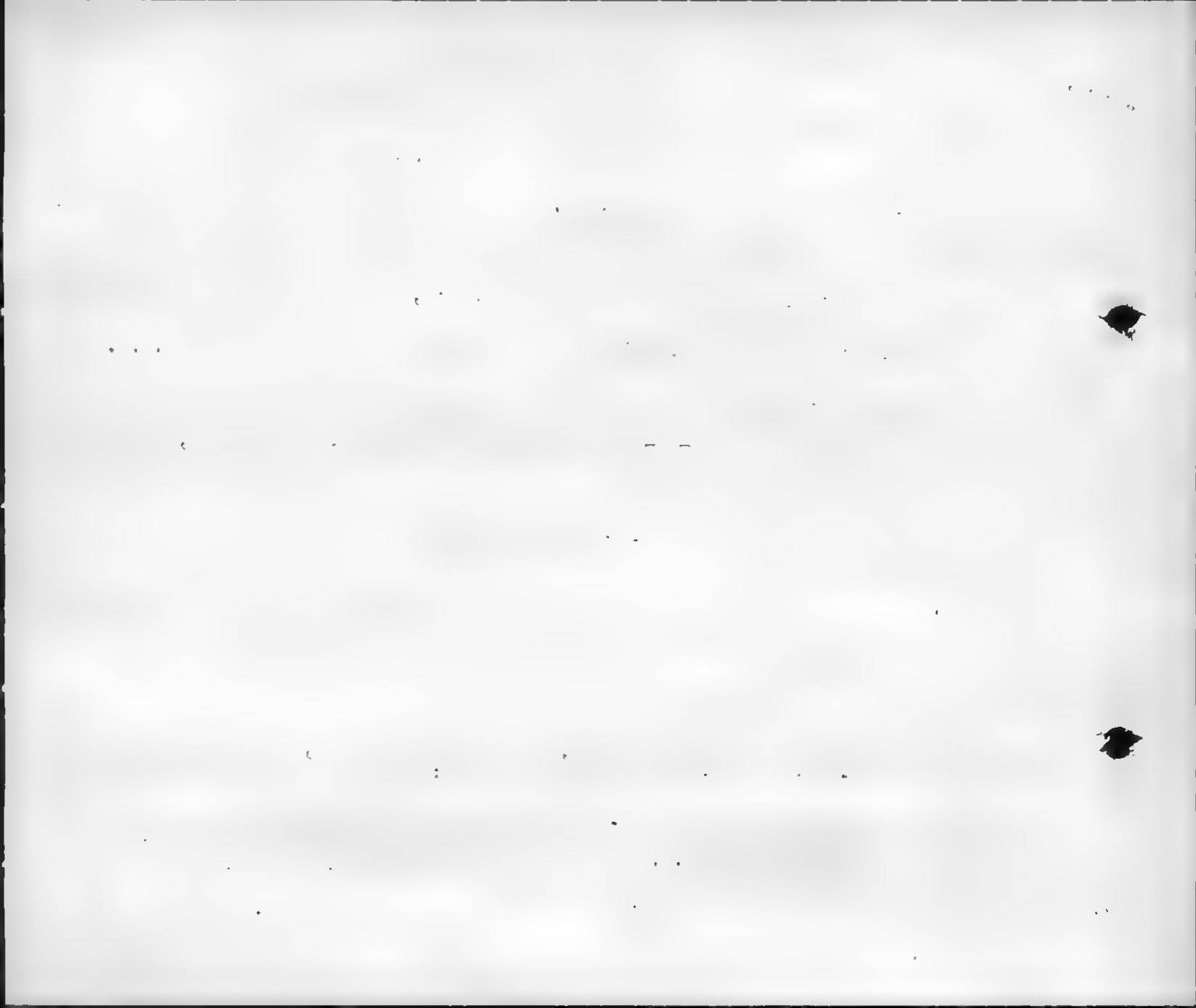
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE West Virginia COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 49 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmont	
3. NAME OF DECEASED (Type or print) First Benigno Middle (none) Last Martinez		4. DATE OF DEATH Month August Day 25 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 15, 1898
9. AGE (In years last birthday) 60 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Trucking	
11. BIRTHPLACE (State or foreign country) Spain		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Francisco Martinez		14. MOTHER'S MAIDEN NAME Marie Alverrez	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 234-01-1547	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia 2013 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Myelogenous Leukemia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 1 Year
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 7, 1958 to August 25, 1958 , that I last saw the deceased alive on August 25, 1958 , and that death occurred at 9:10 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>[Signature]</i> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 8/26/58 National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) ROGER LESTER, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit	22b. DATE THEREOF 8/29/58	22c. NAME OF CEMETERY OR CREMATORY Holy Cross	22d. LOCATION (City, town, or county) (State) Fairmont, W. Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland		24a. REC'D BY REGISTRAR AUG 27 58 DATE	
		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



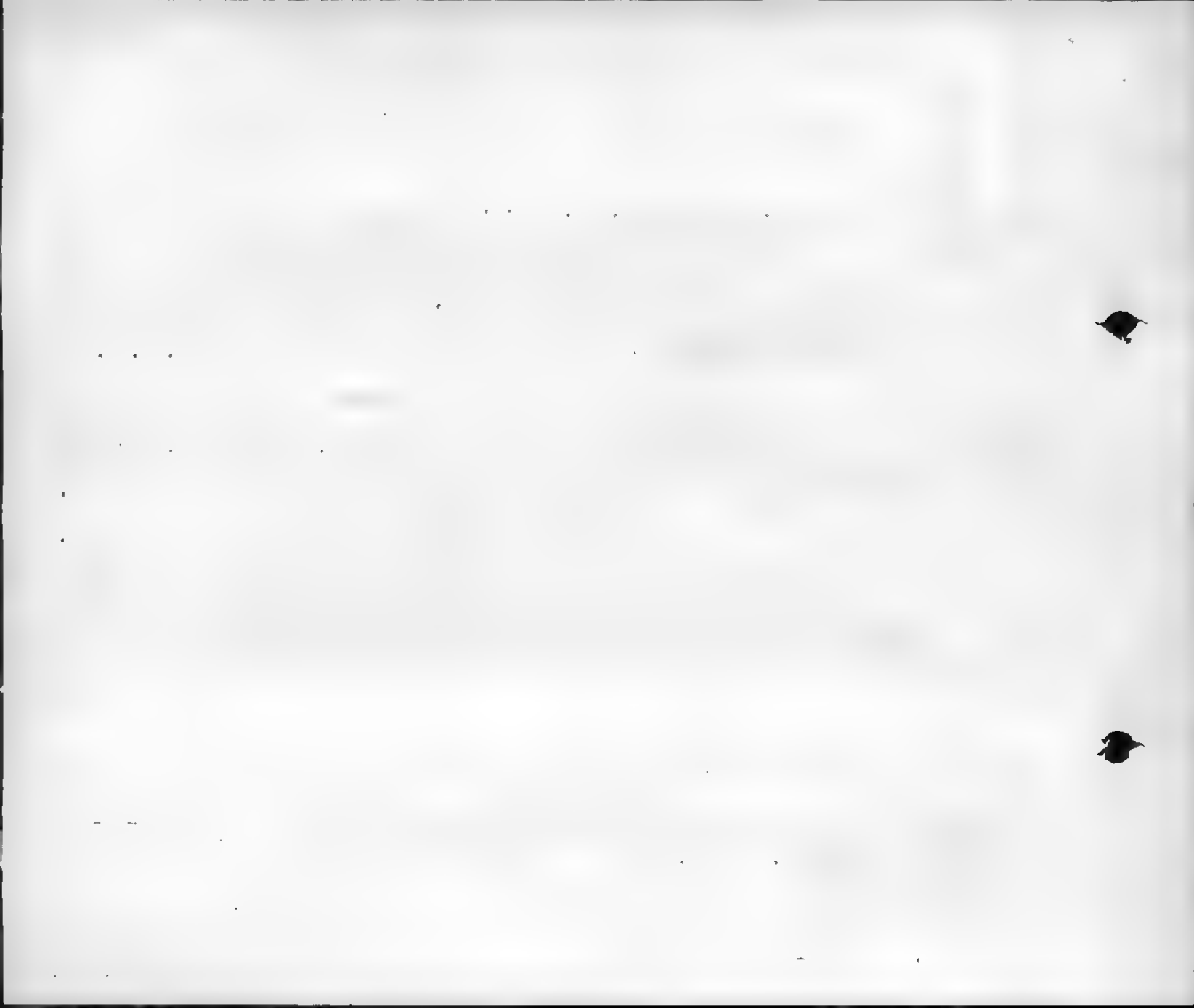
9290

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 172 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Nelle Middle Madaline Last Mason				4. DATE OF DEATH Month August Day 20 Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 18, 1910		9. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Interior decorating inspector - Factory				10b. KIND OF BUSINESS OR INDUSTRY West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles Mason				14. MOTHER'S MAIDEN NAME Eliza Matthews			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unascertainable		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhagic broncho-pneumonia 110X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of the breast with widespread metastases to bone and liver DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 18 hrs. 4 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic incomplete intestinal obstruction with ulceration of						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) stomach & duodenum				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) stomach & duodenum		
20f. (City or town) Bethesda			20g. (County) Montgomery			20h. (State) Md.	
21. I certify that I attended the deceased from March 1, 1958 , to August 20, 1958 , that I last saw the deceased alive on August 20, 1958 , and that death occurred at 1:55A M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 8-20-58 NATIONAL INSTITUTES OF HEALTH BETHESDA 14, MARYLAND							
ACTUAL SIGNATURE <i>Richard H. Moy</i>		PHYSICIAN'S NAME (Type) Richard H. Moy, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/23/58		22c. NAME OF CEMETERY OR CREMATORY Masonic Cemetery		22d. LOCATION (City, town, or county) (State) Shinnston, West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE AUG 22 '58		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and is to be completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



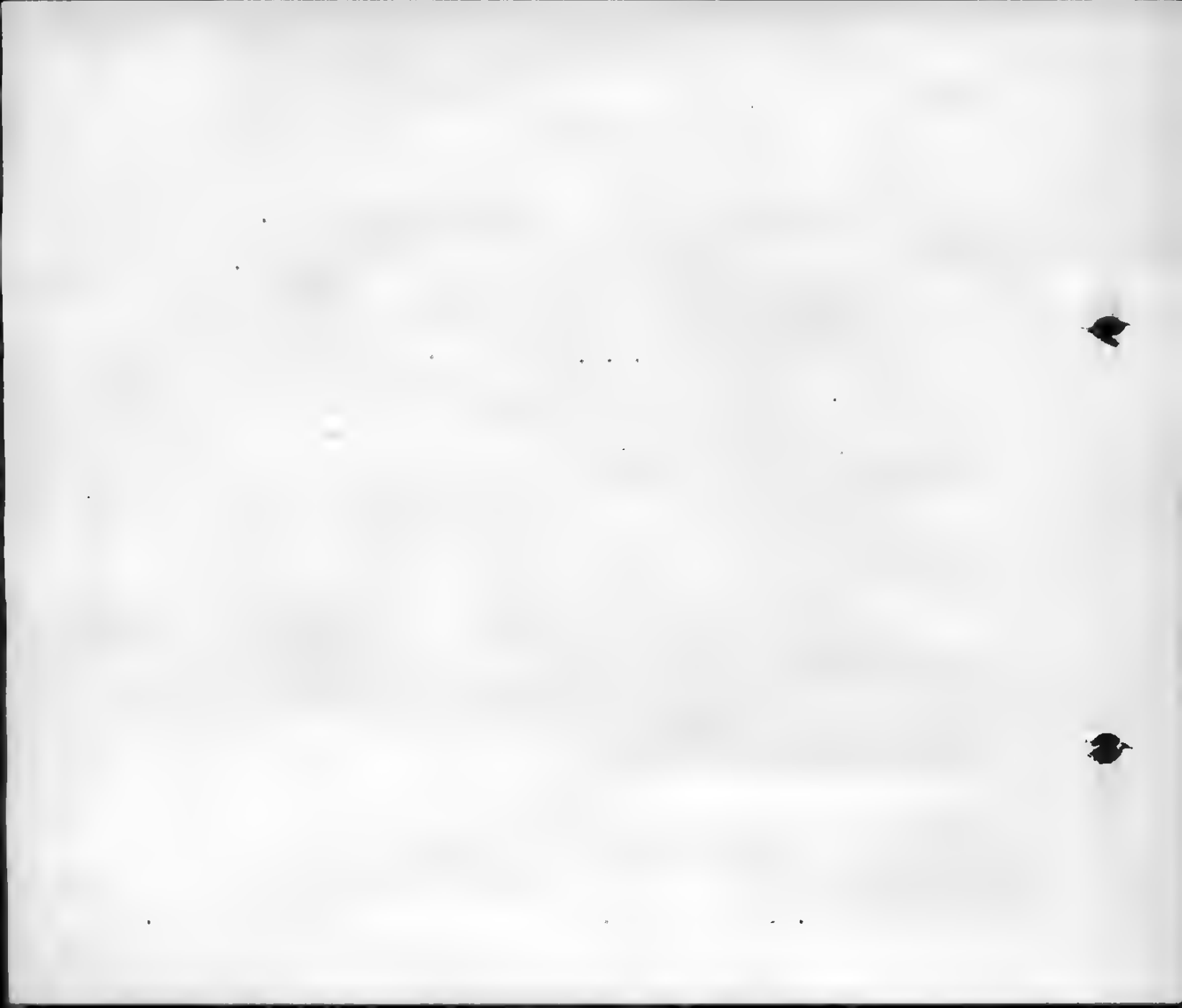
9291 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Damascus</u> c. LENGTH OF STAY IN lb <u>3 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>25605 Ridge Rd</u>		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Damascus</u> d. STREET ADDRESS <u>25605 Ridge Rd.</u> e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Irving Maurice Matney</u>		4. DATE OF DEATH <u>Aug. 30</u> 195 <u>8</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/28/1908</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N.I.H.</u>	11. BIRTHPLACE (State or foreign country) <u>Va.</u>
13. FATHER'S NAME <u>Floyd S. Matney</u>		14. MOTHER'S MAIDEN NAME <u>Evelyn Yates</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>028-03-0668</u>	17. INFORMANT <u>Mr. Pearl Matney</u> Address <u>Ita. 2</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>4:00</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>8/30/58</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept. 3, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Clivet</u>	22d. LOCATION (City, town, or county) (State) <u>Fredorick, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas. J. Mohrman</u> ADDRESS <u>Damascus, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 4 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1 and 2 may be retained for your files. TO FUNERAL DIRECTOR: This certificate should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9292
CERTIFICATE OF DEATH

09279

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boothsda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillindale</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. STREET ADDRESS <u>Crosthaven Drive</u>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Arthur</u> Last <u>Matthews</u>				4. DATE OF DEATH Month <u>8</u> Day <u>7</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>E</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 9 1910</u>	
9. AGE (In years last birthday) <u>48</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>7</u> Hours <u>19</u> Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Labor</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Harry Matthews</u>				14. MOTHER'S MAIDEN NAME <u>Emma Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>117 Fairland</u>			
17. INFORMANT <u>Sister Hattie B. Jackson</u>				Address <u>Colesville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Esophago-Tracheal fistula</u> <u>15x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>secondary to esophageal carcinoma</u> DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>7-15</u> , 19 <u>58</u> , to <u>8-7</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8-7</u> , 19 <u>58</u> , and that death occurred at <u>9:45</u> P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>8/17/58</u>							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.				PHYSICIAN'S NAME (Type) <u>[Signature]</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/12/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Good Hope.</u>		22d. LOCATION (City, town, or county) (State) <u>Colesville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R.L. SNODDEN</u> ADDRESS <u>Rockville, Md.</u>				24a. REC'D BY REGISTRAR <u>Aug 12 1958</u> 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9293 **CERTIFICATE OF DEATH**

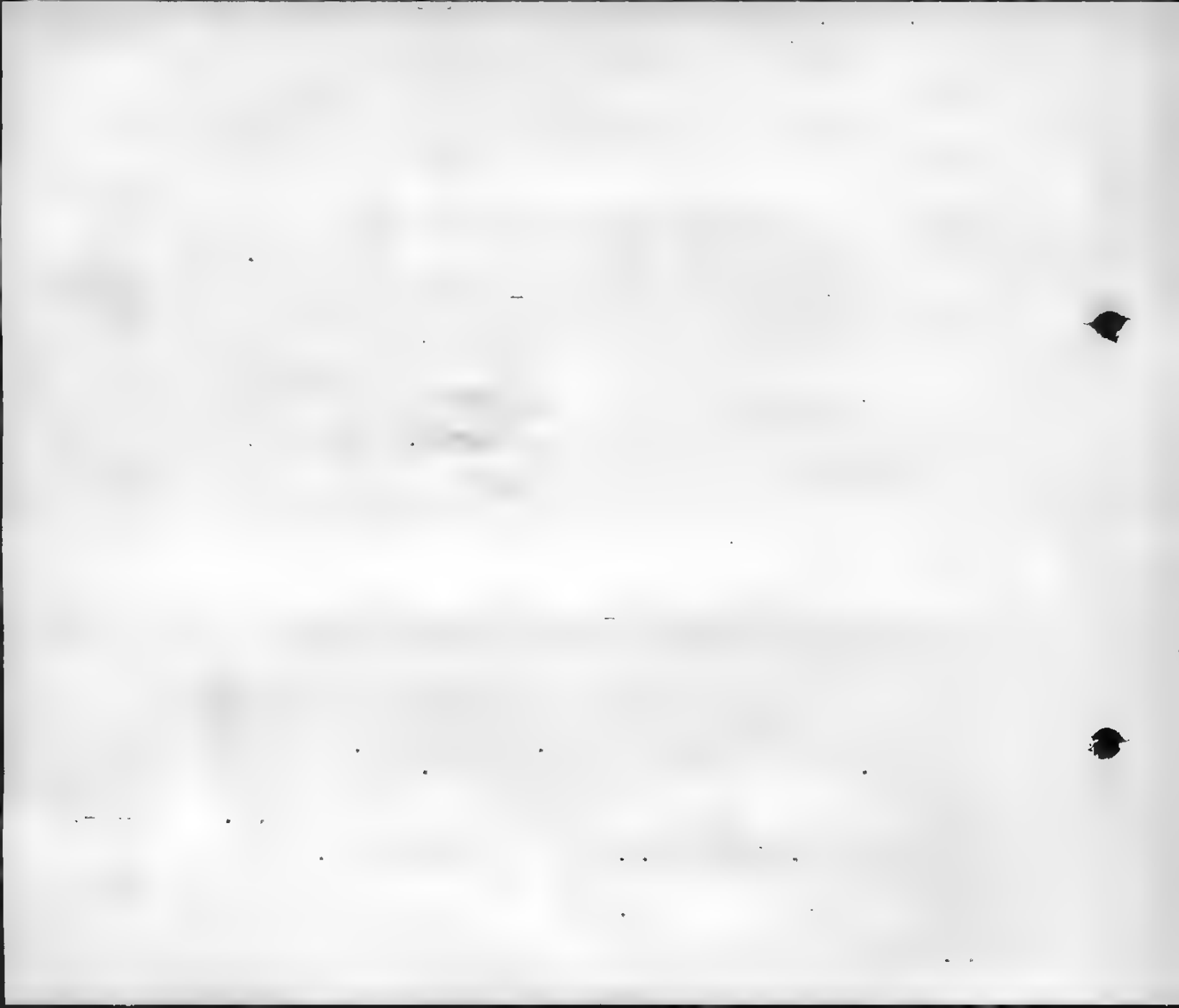
09280

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>																			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>			c. LENGTH OF STAY IN 1b 			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>																	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital</u>				d. STREET ADDRESS <u>Woodland Road</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																
3. NAME OF DECEASED (Type or print) <u>WILLIAM SYKES MAY</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>21</u> Year <u>1958</u>																			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>6-30-1870</u>		9. AGE (In years last birthday) <u>88</u> yrs. <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td></td> <td>Hours</td> </tr> <tr> <td></td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS	Months	Days		Hours		Min.						
IF UNDER 1 YEAR	IF UNDER 24 HRS																						
Months	Days																						
	Hours																						
	Min.																						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saw Mill Worker</u>				10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? 															
13. FATHER'S NAME <u>Isaac H. May</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Elizabeth Hevner</u>																			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT <u>Ira Delawder, Ellicott City, Md</u>																			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td colspan="6" style="padding: 5px;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral embolism</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. </td> <td colspan="2" style="padding: 5px;"> INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> </td> </tr> <tr> <td colspan="6" style="padding: 5px;"> (b) _____ DUE TO (c) _____ </td> <td colspan="2" style="padding: 5px;"></td> </tr> </table>								PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral embolism</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>		(b) _____ DUE TO (c) _____							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral embolism</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>																	
(b) _____ DUE TO (c) _____																							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Atherosclerotic heart disease & chronic myocardial failure</u>																							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)																			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)																
21. I certify that I attended the deceased from <u>Aug. 16, 1958</u> , to <u>Aug. 21, 1958</u> , that I last saw the deceased alive on <u>Aug. 21, 1958</u> , and that death occurred at <u>7.00PM</u> , from the causes and on the date stated above.																							
ACTUAL SIGNATURE <u>Charles S. Whitaker, M.D.</u>				ADDRESS (Street, city or town, state) <u>Clarksville, Md.</u>				DATE SIGNED <u>8-22-58</u>															
PHYSICIAN'S NAME (Type) <u>Charles S. Whitaker M.D.</u>				<u>Clarksville, Md.</u>																			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-23-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns</u>		22d. LOCATION (City, town, or county) (State) <u>Ellicott City, Md</u>																	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F.C. Higinbotham</u>				ADDRESS <u>Ellicott City, Md</u>		24a. REC'D BY REGISTRAR <u>Aug 25 58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>															

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9294

CERTIFICATE OF DEATH

09281

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1610 NEELEY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
c. LENGTH OF STAY IN 1b <u>8 yrs</u>				d. STREET ADDRESS <u>1610 NEELEY</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Silver Spring</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>JOHN HENRY Mc KAY</u> First Middle Last				4. DATE OF DEATH <u>AUG 8</u> Month Day Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG 4, 1881</u> 77 yrs	
9. AGE (In years last birthday) <u>77</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gen'l Foreman Capital Transit Co.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Capital Transit Co.</u>		11. BIRTHPLACE (State or foreign country) <u>DC</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>William Mc Kay</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Lang</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>578-10-5112</u>		17. INFORMANT <u>Mrs Elizabeth Mc Kay - wife</u> Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> DUE TO <u>ARTERIO-SCLEROTIC cerebral</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Vascular Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arterio-sclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>3 mos +</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>July 17, 1958</u> to <u>AUG 8, 1958</u> that I last saw the deceased alive on <u>AUG 8, 1958</u> and that death occurred on <u>10:35</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wolcott L. Etienne</u> M.D. <u>4713-BERYN RD</u>				DATE SIGNED <u>8/8/58</u>			
PHYSICIAN'S NAME (Type) <u>WOLCOTT L. ETIENNE College Park, MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/12/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR <u>AUG 12 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. K...</u>	



9295

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norbeck				c. LENGTH OF STAY IN 1b 1 yr 8 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St Philomena Rest Home				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kent Village, Md.			
d. STREET ADDRESS 2720 74th Avenue,.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARGARET Middle ELLEN Last Mc NAMARA				4. DATE OF DEATH Month August Day 30 , Year 19 58-			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan 25, 1871	
9. AGE (In years birthday) yrs 87		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Pittsburg Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Patrick Mc Linden				14. MOTHER'S MAIDEN NAME Margaret E ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Thomas E Mc Namara Address Kent Village Maryland.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pneumonia DUE TO Congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) A.S.C.V.D. DUE TO (c) 3 weeks years						INTERVAL BETWEEN ONSET AND DEATH 3 weeks years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Rockville				20g. (County) Rockville		20h. (State) Md.	
21. I certify that I attended the deceased from Aug 30, 1958 to Aug 30, 1958 , that I last saw the deceased alive on Aug 30, 1958 , and that death occurred at 12600 CARLAND Drive, Rockville, Md. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles M Weber				DATE SIGNED SEP 2 '58			
PHYSICIAN'S NAME (Type) Charles M Weber				ADDRESS Rockville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 4, 1958		22c. NAME OF CEMETERY OR CREMATORY Old Calvary Cemetery		22d. LOCATION (City, town, or county) (State) Greenpoint Brooklyn New York.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Maryland.		24a. REC'D BY REGISTRAR SEP 2 '58	
24b. REGISTRAR'S SIGNATURE C. S. Howard							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 4, 10b & 11, Film G-243 9/2/58, cac.

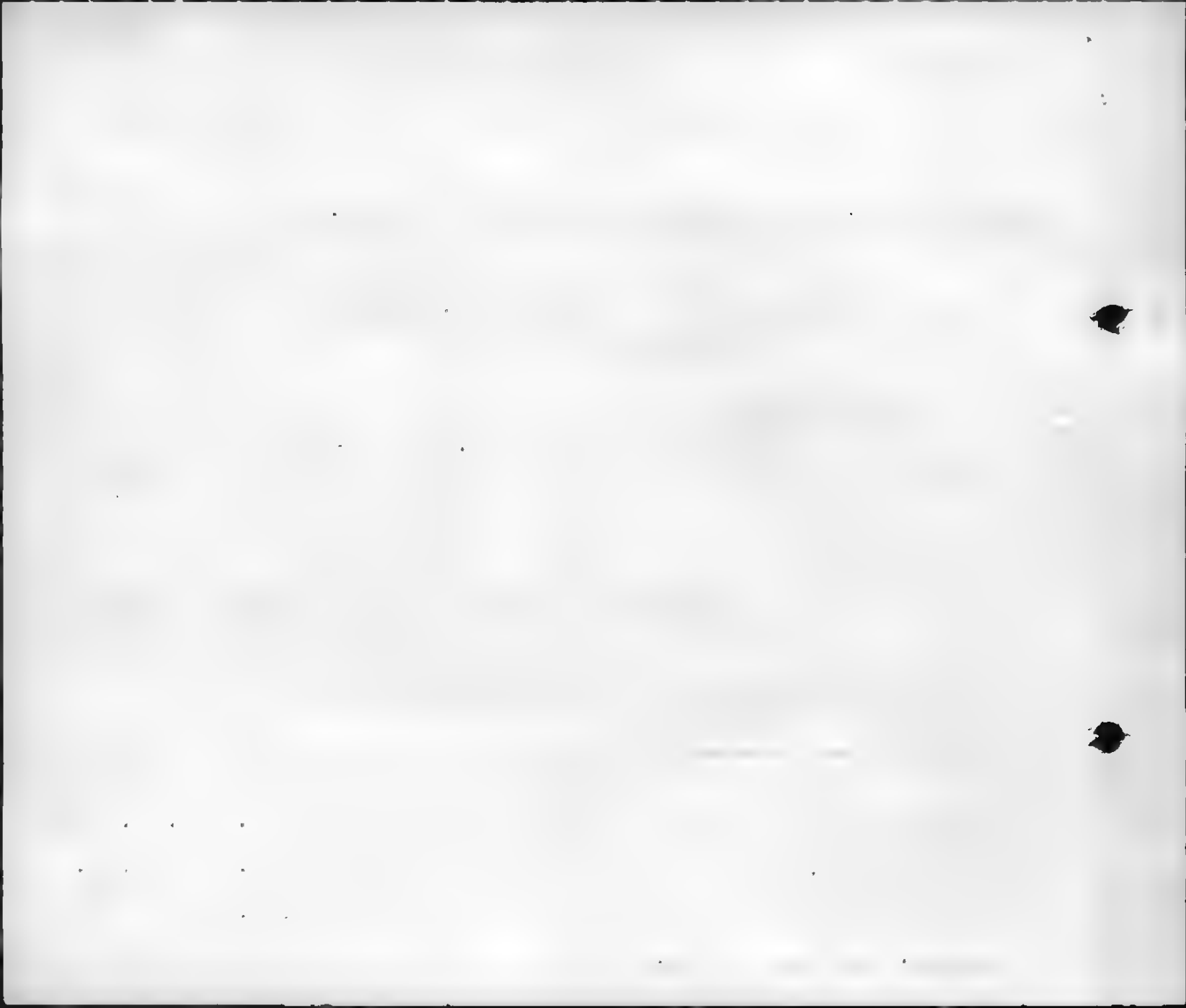
09283

9296

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Resmore San't Hosp</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Resmore Rest Home</u>		d. STREET ADDRESS <u>4317 Maple Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Harold</u> Middle <u>Mellor</u> Last <u>Mellor</u>		4. DATE OF DEATH Month <u>August</u> Day <u>16</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 25, 1883</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>	
11. BIRTHPLACE (State or foreign country) <u>Ireland/ England</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Joseph Mellor</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>094-10-8529</u>	
17. INFORMANT <u>Mary S. Mellor - Item # 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure -</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Memoranda from Urinary Bladder -</u> DUE TO (c) <u>Male status Carcinoma of Bladder & Prostate & Benign</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of sigmoid-bladder - 1955. C.V. Adenocarcinoma of Hemipelgia.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH. <u>24 hr.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1950</u> , 19 <u>50</u> , to <u>date</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>17/16 Aug.</u> 19 <u>58</u> , and that death occurred at <u>7:30</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7936 Old Georgetown Rd. Bethesda, Md.</u> DATE SIGNED <u>8/16/58</u>			
ACTUAL SIGNATURE <u>John G. Ball</u>		M.D. <u>7936 Old Georgetown Rd. Bethesda, Md.</u>	
PHYSICIAN'S NAME (Type) <u>John G. Ball</u>		<u>7936 Old Georgetown Rd. Bethesda, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/19/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR DATE <u>AUG 19 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Evans</u>	



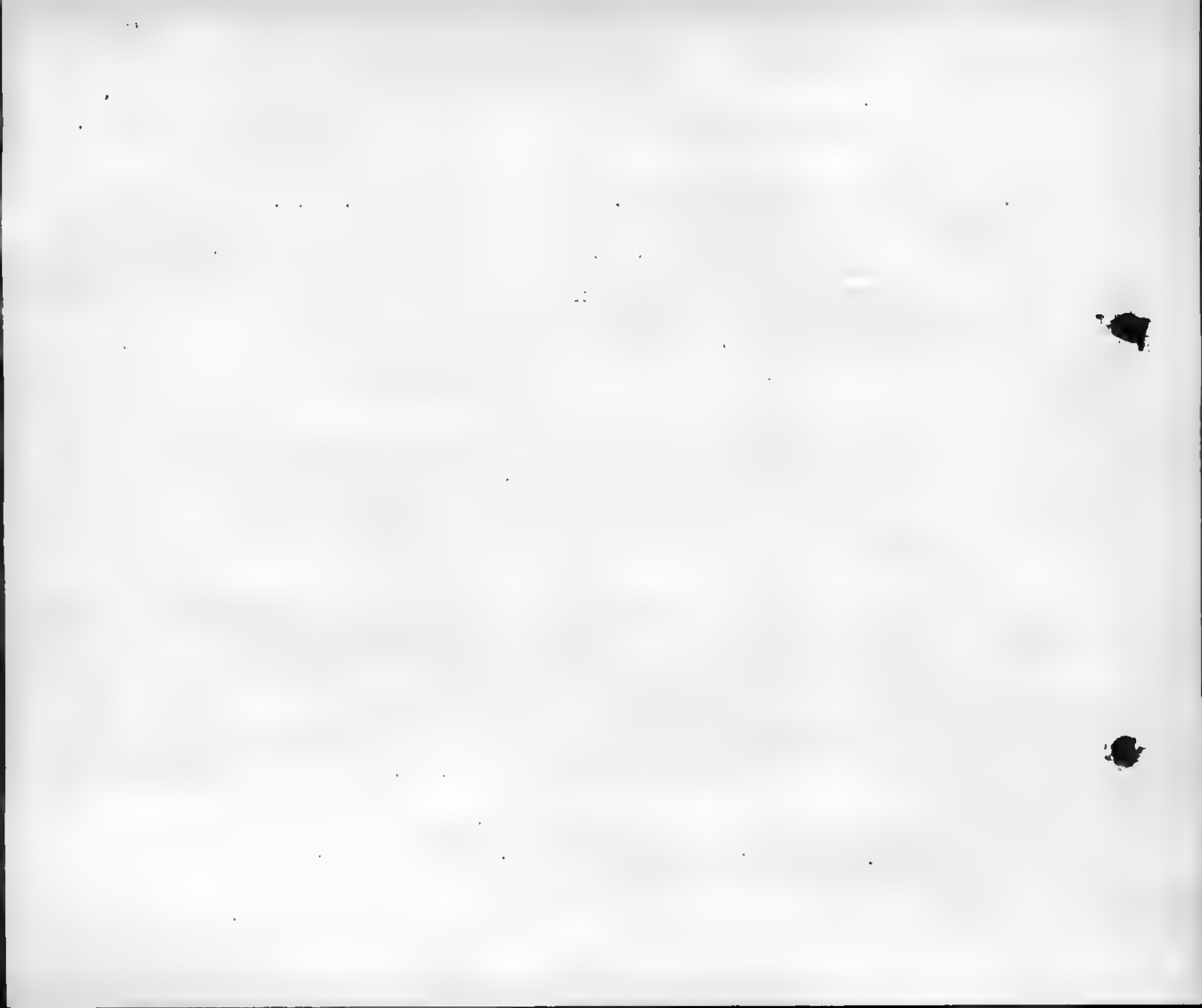
9297

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>		d. STREET ADDRESS <u>7518 9th St., N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Louis</u> Middle <u>(nmn)</u> Last <u>MESTESKY</u>		4. DATE OF DEATH Month <u>August</u> Day <u>17</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>October 12, 1904</u>
9. AGE (In years last birthday) <u>53</u> yrs		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mariner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy, (Retired)</u>	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Julius Metesky</u>		14. MOTHER'S MAIDEN NAME <u>Ida (Last Name Unknown)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes</u> <u>NW-II.</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Official Navy Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and, (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>16 August, 1958</u> to <u>17 August, 1958</u> , that I last saw the deceased alive on <u>17 August, 1958</u> , and that death occurred at <u>8:45 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. E. Gorsuch</u>		ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Bethesda, Md.</u> DATE SIGNED <u>8-18-58</u>	
PHYSICIAN'S NAME (Type) <u>G. E. GORSUCH, LT, MC, USN</u>		<u>U.S. Naval Hospital, Bethesda, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-20-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Danzanski & Sons</u> ADDRESS <u>Danzanski, 8501 14th St., Washington, D. C.</u>		24a. REC'D BY REGISTRAR <u>AUG 19 58</u>	24b. REGISTRAR'S SIGNATURE <u>William S. ...</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon between Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



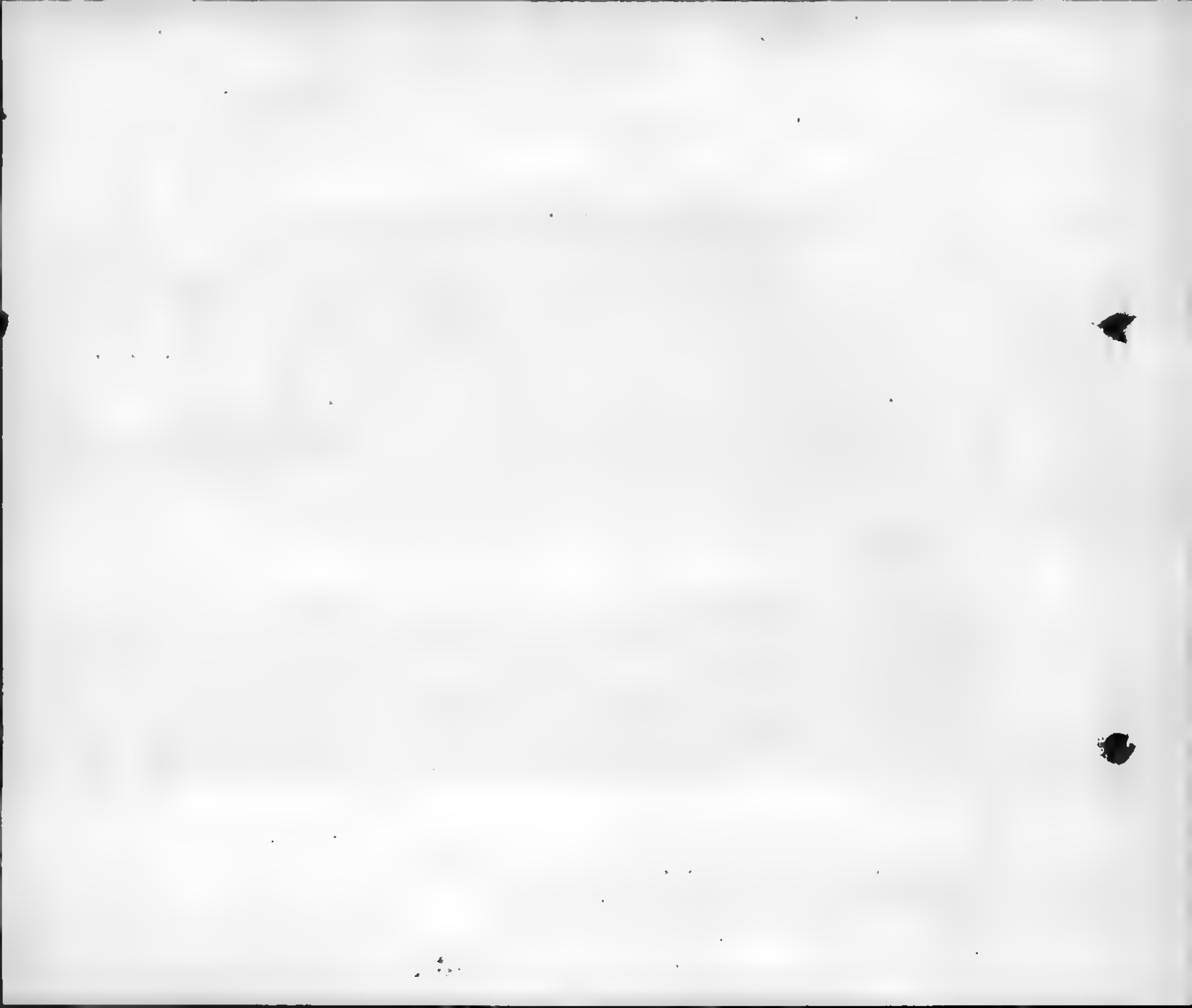
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9298
CERTIFICATE OF DEATH

09285

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Fairfax</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ethelwyn</u> Middle <u>Irene</u> Last <u>Meyer</u>				4. DATE OF DEATH Month <u>August</u> Day <u>8</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 2, 1909</u>		9. AGE (In years last birthday) <u>49</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Social Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Edward S. Hine</u>				14. MOTHER'S MAIDEN NAME <u>Ethelwyn A. Edwards</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unascertainable</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>204.2</u> IMMEDIATE CAUSE (a) <u>Cerebrovascular Hemorrhage</u> DUE TO <u>1</u> <u>Acute Myeloblastic leukemia</u> (b) DUE TO _____ (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <u>3 Weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 8, 1958</u> , to <u>August 8, 1958</u> , that I last saw the deceased alive on <u>August 8, 1958</u> , and that death occurred at <u>6:00 P.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. Richard Lee MD</u> M.D.				ADDRESS (Street, city or town, state) <u>The Clinical Center</u> <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>G. RICHARD LEE, M.D.</u>				DATE SIGNED <u>8/9/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 13, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Pearson Funeral Home</u> <u>R. M. Jackson</u>				24a. REC'D BY REGISTRAR <u>Falls Church Va</u>		24b. REGISTRAR'S SIGNATURE <u>AUG 12 1958 Arthur S. Krueger</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9189

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Maryland</u>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>12 hours</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		d. STREET ADDRESS <u>1808 West Avenue</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Howard</u> Middle <u>James</u> Last <u>Minchin</u>		4. DATE OF DEATH Month <u>August</u> Day <u>24</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-24-58</u>
9. AGE (In years last birthday) yrs. <u>11</u> Months <u>11</u> Days <u>31</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Kelvin Lennard Minchin</u>		14. MOTHER'S MAIDEN NAME <u>Shirley Joan Lonergan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mother's Chart</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity, Pulmonary atelectasis</u> 7625 DUE TO (b) <u>Cerebral congestion & edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>(secondary)</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-24</u> , 19 <u>58</u> , to <u>8-24</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8-24</u> 19 <u>58</u> , and that death occurred at <u>3:13</u> PM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>Emma Hughes</u> M.D. <u>Takoma Park, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Emma Hughes, M.D. Washington Sanitarium & Hospital, Takoma Park, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>8-27-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Washington San. & Hosp.</u>		22d. LOCATION (City, town, or county) (State) <u>Takoma Park 12, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Hark</u>		ADDRESS <u>Washington San. & Hosp.</u>	
24a. REC'D BY REGISTRAR DATE <u>SEP 2 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hark</u>	

MEDICAL CERTIFICATION

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9299

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
c. LENGTH OF STAY IN 1b 13 days		d. STREET ADDRESS 4028 8th Street, N. E.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Daniel Middle Leo Last Moriarty		4. DATE OF DEATH Month August Day 4 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 2, 1904
9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secret Service Officer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John J. Moriarty		14. MOTHER'S MAIDEN NAME Julia Hogan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) 1929 - 1932		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ? Hepatic Coma 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) Cirrhosis, Liver - severe DUE TO (c) Acute Myelogenous Leukemia		INTERVAL BETWEEN ONSET AND DEATH 1-2 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 22 19 58 , to August 4, 1958 , that I last saw the deceased alive on August 4, 19 58 , and that death occurred at 5:20AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Leonard Garren M.D.		ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 8/4/58	
PHYSICIAN'S NAME (Type) Leonard Garren, M.D.		National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 8-5-58	22c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	22d. LOCATION (City, town, or county) (State) St. Paul, Minn.
23. FUNERAL DIRECTOR'S SIGNATURE Timothy Harlow Jr. Home ADDRESS 3831 Boyia Dr. N.W.		24a. REC'D BY REGISTRAR W. H. D. C. DATE AUG 6 '58	
24b. REGISTRAR'S SIGNATURE W. H. D. C.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is to be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09288

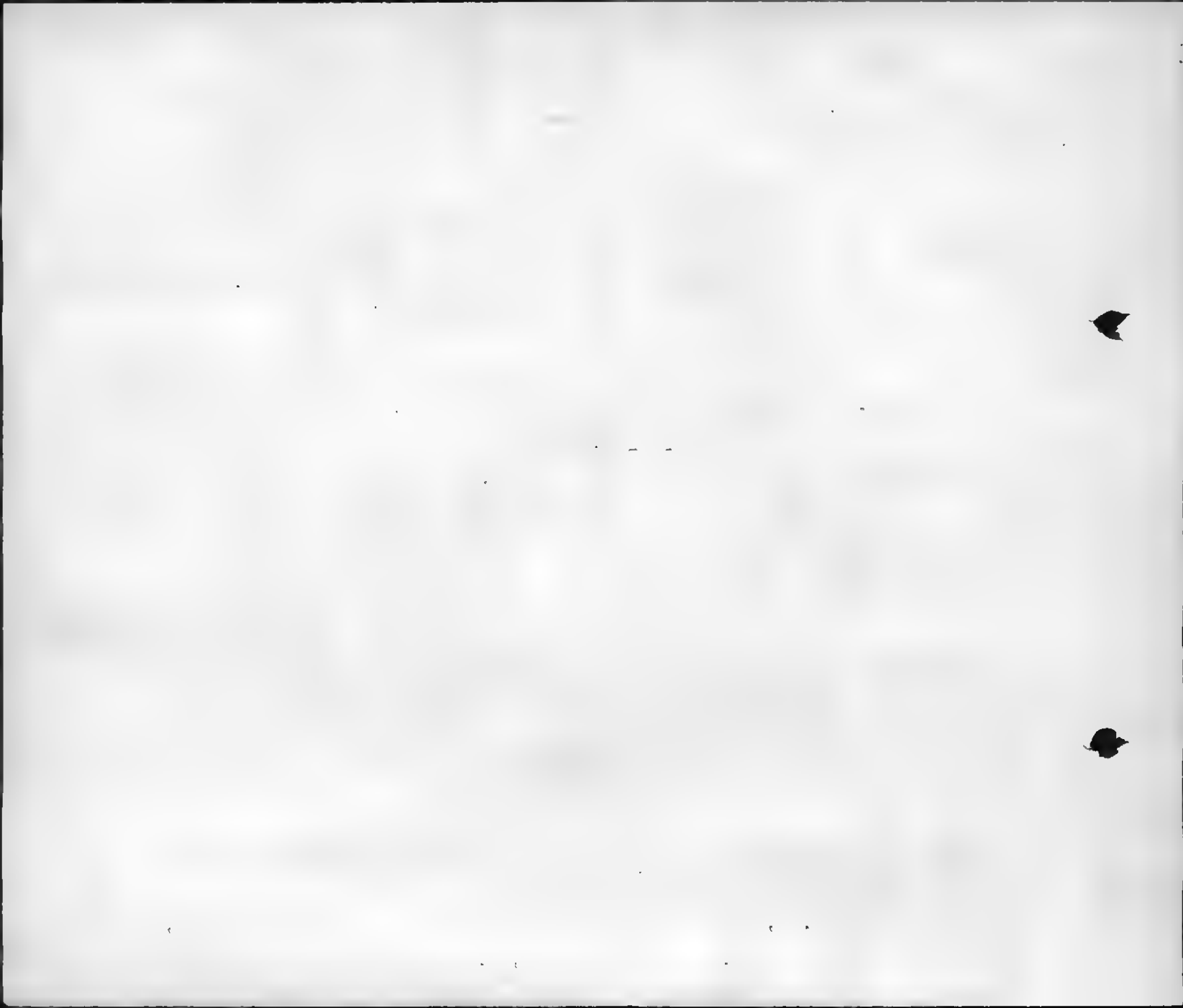
9201

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 1 and 2 may be retained for your files. TO FUNERAL DIRECTOR: If page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>6 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		d. STREET ADDRESS <u>1 4604 Bayne Ct</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4604 Bayne Ct</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Anna Elizabeth Morris</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>25</u> Year <u>1958</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-3-126</u>	9. AGE (in years last birthday) <u>31</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS Hours <u> </u> M n. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>16a</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Edwin L. Humphries</u>				14. MOTHER'S MAIDEN NAME <u>Marquette Bayne</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-32-6536</u>		17. INFORMANT <u>Theresa Morris - Same as 14b</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Multiple Sclerosis</u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed 6 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Brusche</u>		EXAMINER'S NAME (Type) <u>FRANK J. BRUSCHE</u>		M.D. <u> </u>		DATE SIGNED <u>8-25-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>AUG. 28, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lawrence E. Humphrey</u>		ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



1 X
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9300 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09289

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Mar Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Mar Park - Bethesda</u>	
c. LENGTH OF STAY IN 1b <u>4 1/2 yrs</u>		d. STREET ADDRESS <u>5810 Augusta Lane</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington 16 DC</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Leland</u> First <u>Wayne</u> Middle <u>Morrow</u> Last		DATE <u>Aug 4 1958</u> DEATH	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-28-1900</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Government employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ohio</u>	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jeremiah H. Morrow</u>		14. MOTHER'S MAIDEN NAME <u>Nannie Duddleson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, not or unknown) <input type="checkbox"/> If yes, give war or dates of service		16. SOCIAL SECURITY NO. <u>6500</u>	
17. INFORMANT <u>Marjorie Shanks</u>		Address <u>6500 Wimpsey Rd Bethesda 41, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u>420.1</u> DUE TO <u>Coronary occlusion</u> (a), stating the underlying cause last. (c) <u>420.1</u> DUE TO <u>Coronary occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.1</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Aug 4 1958</u>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/8/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Corington, Va</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Cherry Chase Funeral Home</u>		24a. REC'D BY REGISTRAR <u>Aug 8 '58</u>	
ADDRESS <u>2114 N. Washington St</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred</u>	

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1, 2, and 3 may be retained for your files. TO FUNERAL DIRECTOR: Pages 1, 2, and 3 should be used as a burial-transit permit. File pages 1 only with the State Board of Health, or its designated agent, prior to burial; cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 237-212 2/19/58

09290

9301

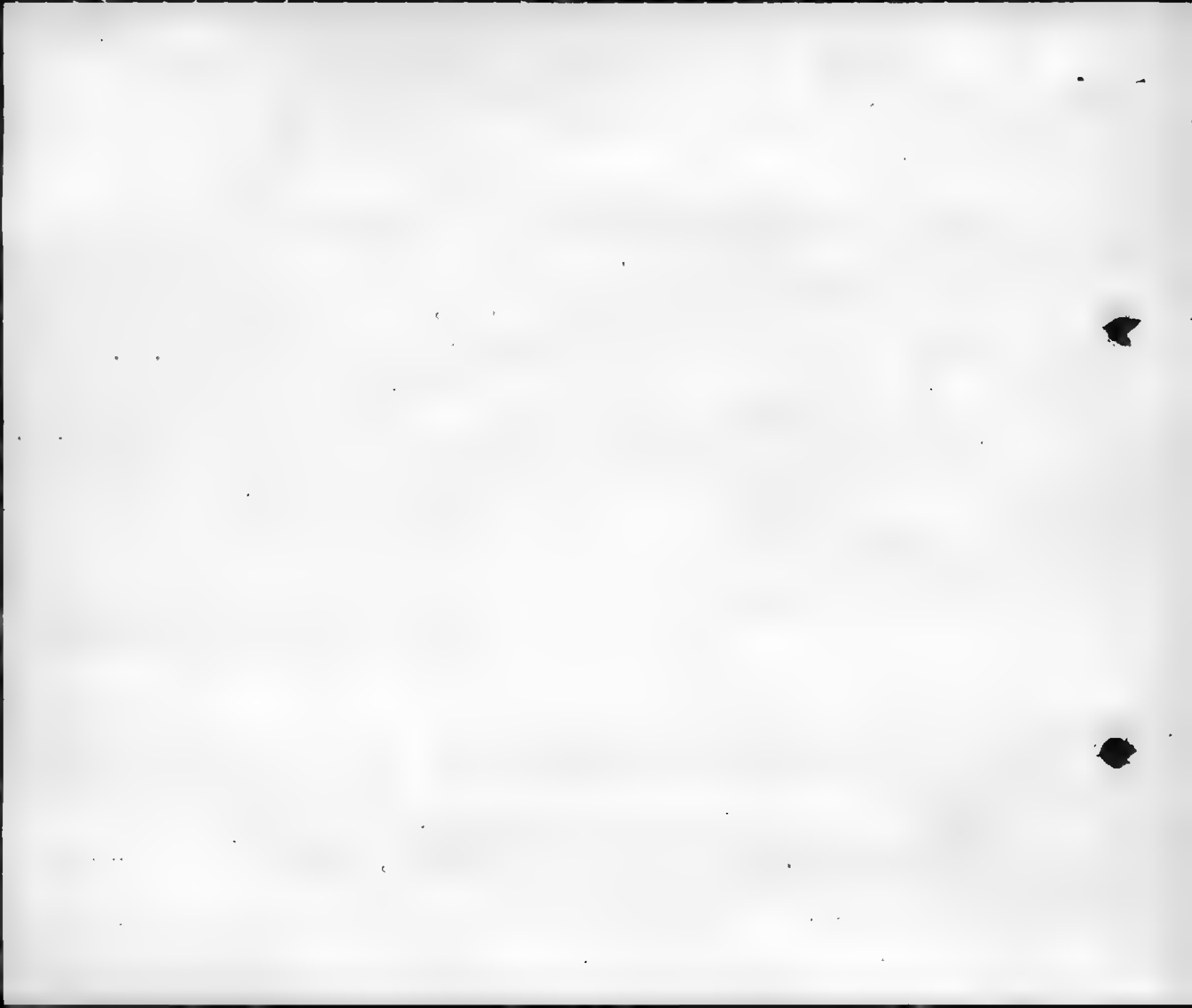
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Germantown Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Marylander		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANNIE Middle E. Last MOYER		4. DATE OF DEATH Month August Day 2 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 17, 1871
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR: Months 9 Days 15 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (State or foreign country) U. S.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Ambrose Moyer		14. MOTHER'S MAIDEN NAME Elizabeth Stombock	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Marylander Records		Address Germantown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 21, 1957 to Sept 21, 1958 that I last saw the deceased alive on Sept 21, 1958 and that death occurred at M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 			
ACTUAL SIGNATURE M.D. 			
PHYSICIAN'S NAME (Type) JAMES P. KERR Damascus, Maryland 8-2-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-5-58	
22c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery		22d. LOCATION (City, town, or county) (State) Montgomery County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR DATE AUG 5 '58		24b. REGISTRAR'S SIGNATURE 	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9302

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09291

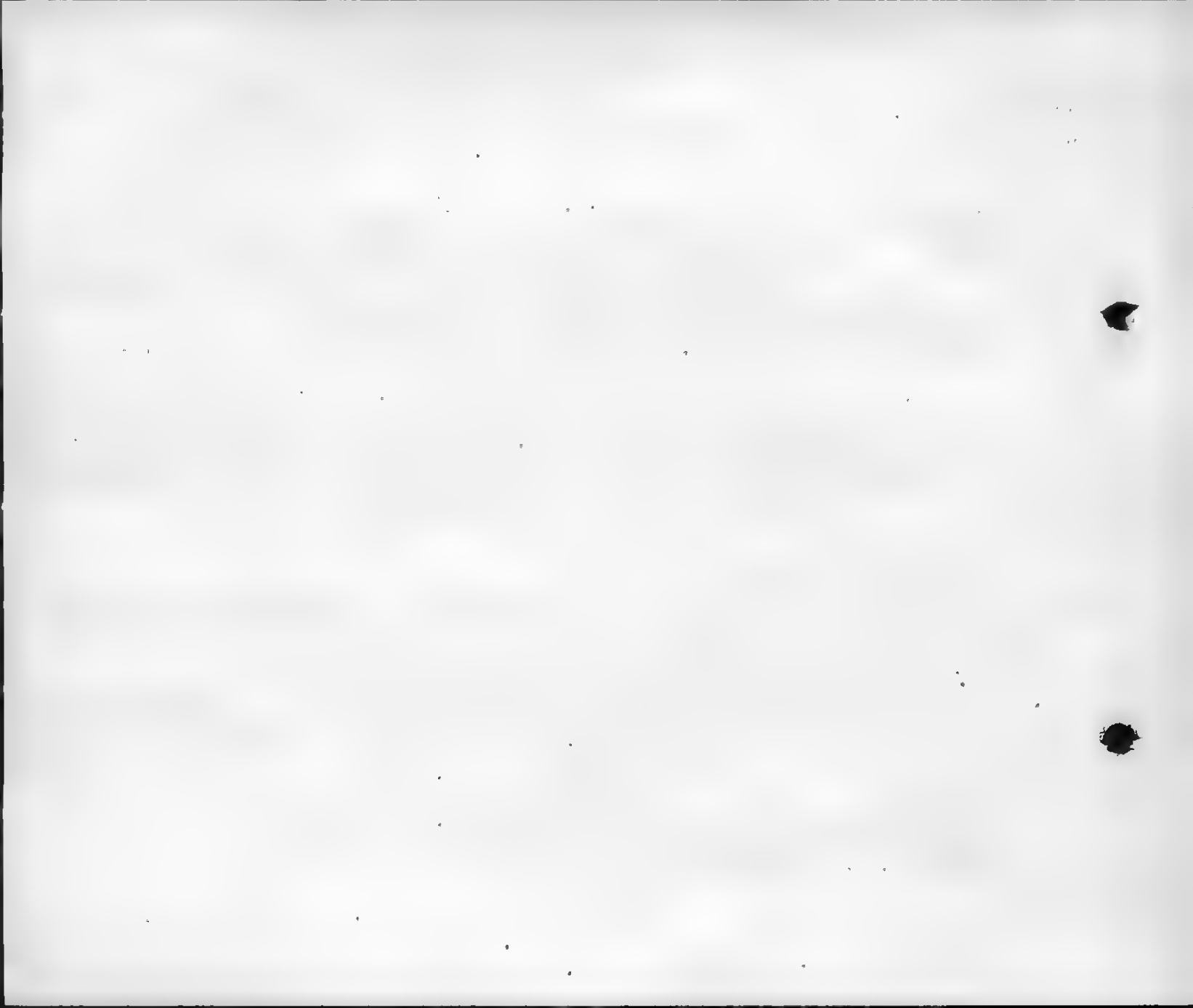
CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE New York b. COUNTY Queens	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 29 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, NNMC, Bethesda, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edward Middle Frank Last NOLAN		4. DATE OF DEATH Month August Day 8 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-5-93
9. AGE (In years last birthday) yrs. 65		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Administrative		10b. KIND OF BUSINESS OR INDUSTRY U. S. Government	
11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank H. NOLAN		14. MOTHER'S MAIDEN NAME Elizabeth J. SAUNDERS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO 060-07-3259	
17. INFORMANT Mrs. Rae F. Nolan (wife), same as #2 above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abdominal carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (Primary site probably pancreas) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 10 , 19 58 , to August 8 , 19 58 , that I last saw the deceased alive on August 8 , 19 58 , and that death occurred at 7:47P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE J. E. McClenathan M.D.		ADDRESS (Street, city or town, state) U. S. Naval Hospital, NNMC DATE SIGNED 8-9-58	
PHYSICIAN'S NAME (Type) J. E. MC CLENATHAN, CDR, MC, USN		Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-13-58	
22c. NAME OF CEMETERY OR CREMATORY Northwood Cemetery		22d. LOCATION (City, town, or county) (State) No. Philadelphia, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co., 1400 Chapin St., N.W.		24a. REC'D BY REGISTRAR AUG 12 1958 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9190

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u>				f. STREET ADDRESS <u>1509 Dublin Dr.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>OWENS</u>				4. DATE OF DEATH Month <u>8-3</u> Day <u>58</u> Year <u>19</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-3-58</u>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>USA - Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Rome Boy Owens</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Nell Kniedy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO		17. INFORMANT <u>mother's Chart</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL EDEMA + HYPEREMIA</u> <u>1600</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>5 HRS.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Hour _____ o. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-3</u> , 19 <u>58</u> , to <u>8-3</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8-3</u> , 19 <u>58</u> , and that death occurred at <u>7:05 P.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L. B. Snow</u>				ADDRESS (Street, city or town, state) <u>9013 Flower Ave</u>		DATE SIGNED <u>8/3/58</u>	
PHYSICIAN'S NAME (Type) <u>L. B. Snow, M.D.</u>				M.D. <u>SILVER SPRING, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>8-5-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium & Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Takoma Park Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Hare</u>				ADDRESS <u>Washington San. & Hosp.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 8 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>			



9303

CERTIFICATE OF DEATH

09293

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			
c. LENGTH OF STAY IN 1b 29 years				d. STREET ADDRESS 2109 HANOVER STREET			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2109 HANOVER STREET				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF ELLSIE C. PENICKS (Type or print) First Middle Last				4. DATE OF DEATH AUGUST 23 Month Day Year 1958			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 20, 1885		9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK NAT'L. DEFENSE D. A. R.		10b. KIND OF BUSINESS OR INDUSTRY SOUTH DAKOTA		11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME CYRUS RAYNSFORD				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 579-16-6800		17. INFORMANT THOMAS B. PENICKS, 2109 HANOVER ST., SILVER SPRING			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Carcinoma of Liver INTERVAL BETWEEN ONSET AND DEATH 2 days 7 mo.						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/24/58 , 19 58 , to 8/23 , 19 58 , that I last saw the deceased alive on 8/23 , 19 58 , and that death occurred at 10:25 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 9321 GEORGIA AVE., SILVER SPRING DATE SIGNED 8/24/58 SIGNATURE Naomi T. Lucius M.D. 9321 GEORGIA AVE., SILVER SPRING PHYSICIAN'S NAME (Type) NAOMI T. LUCIUS							
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF AUG. 24, 1958		22c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CREMATORY		22d. LOCATION (City, town, or county) (State) PRINCE GEORGE'S CO., MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner & Pumphrey				24a. REC'D BY REGISTRAR DATE AUG 26 '58		24b. REGISTRAR'S SIGNATURE Charles S. Hume	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and a copy is filed in the office of the Registrar, page 3 should be detached and used as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9304

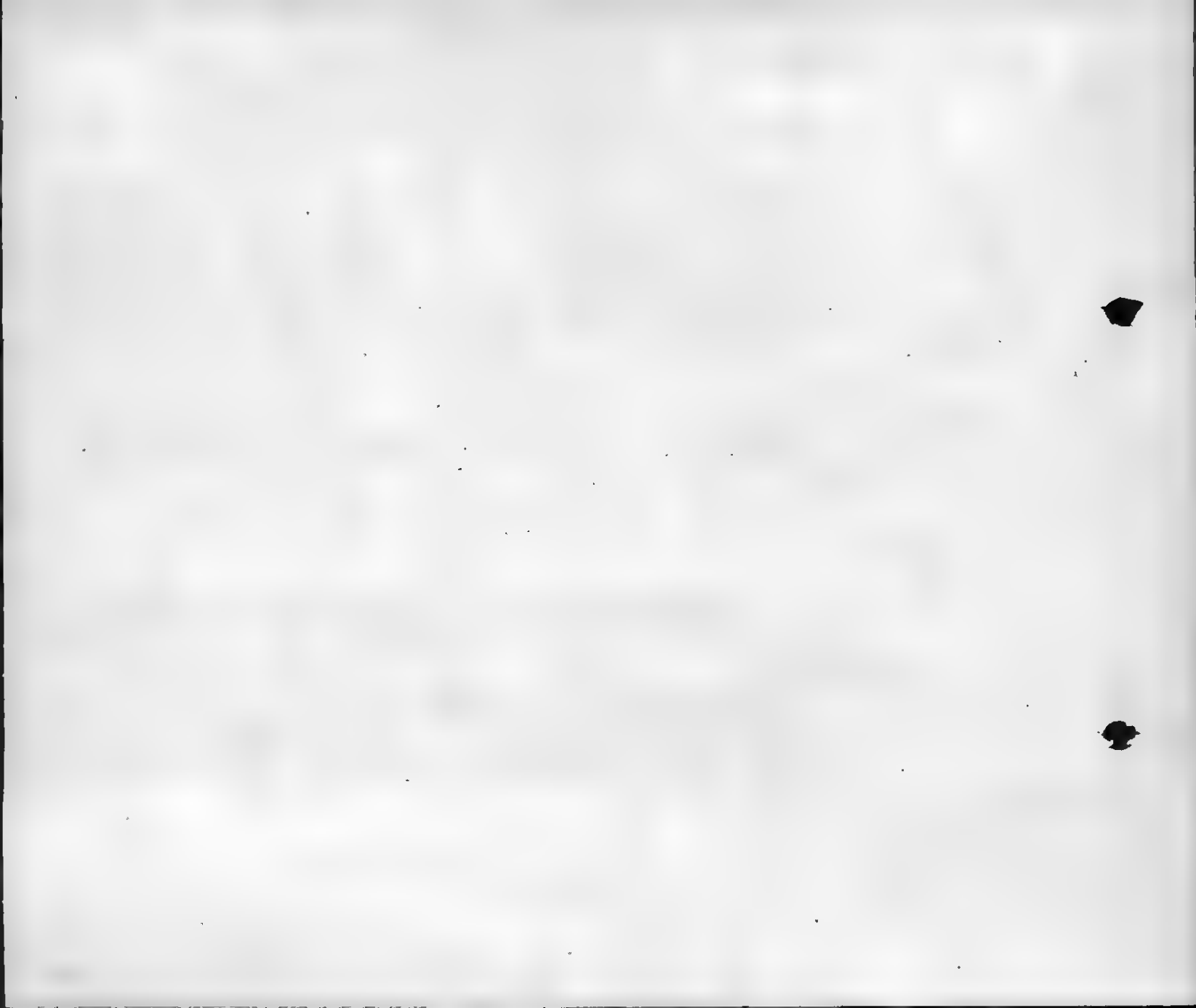
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE FLORIDA b. COUNTY BROWARD	
b. CITY OR TOWN (If outside corporate limits, write R.U.R.A. and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HOLLYWOOD	
c. LENGTH OF STAY IN 1b 2 MONTHS		d. STREET ADDRESS 1829 FUNSTON STREET	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 731 SILVER SPRING AVENUE			
3. NAME OF DECEASED (Type or print) NELLIE CAROLINE PERSON		4. DATE OF DEATH AUGUST 17 19 58	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 1, 1875
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR <input type="checkbox"/> Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/> Hours <input type="checkbox"/> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) ANGEL ISLAND, CALIFORNIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME FREDERICK LUTZE		14. MOTHER'S MAIDEN NAME ELLEN P. EDGERTON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT JOHN T. McMENOMY, 731 SILVER SPRING AVE., S.S.,		Address MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arterio sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 min 20 yr.			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John G. Ball		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JOHN G. BALL		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF AUG. 20, 1958	
22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY, FORT MYER, VA.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Maxwell E. Humphrey		24a. REC'D BY REGISTRAR AUG 22 '58	
ADDRESS SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	





9306 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: This certificate should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		e. IS RECORD MADE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Marsha Lynn Phillips</u>		4. DATE OF DEATH <u>August 13</u> 1958	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 1, 1951</u>
9. AGE (In years last birthday) <u>7</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Stanley Thomas Phillips</u>		14. MOTHER'S MAIDEN NAME <u>Dorothy Ricketts</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mother</u>		Address <u>Dorothy R. Phillips</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Anoxia</u> <u>849X</u> DUE TO (b) <u>Cerebral lacerations and subdural hematoma</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) <u>Fracture, left parietal and occipital bones</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u> <u>1 hour</u> <u>3 3/4 hrs.</u> <u>3 3/4 hrs.</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Fell while riding bicycle</u>	
20c. TIME OF INJURY Month, Day, Year <u>6:15</u> p.m. <u>8-13</u> 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>sidewalk</u>		20f. (City or town) (County) (State) <u>Rockville monty md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>8-14-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/16/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion</u>		22d. LOCATION (City, town, or county) (State) <u>Bethesda, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>AUG 18 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



9307 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 3 should be used as a burial-transit permit. File pages 1 or 2 with the State Board of Health, or its designated agent, to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>35 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		d. STREET ADDRESS <u>1907 Luzerne Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1907 Luzerne Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Jesse Garfield Pratt</u>				4. DATE OF DEATH <u>Aug 27 1958</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-24-81</u>	
9. AGE (In years last b. (day)) <u>77</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Photographer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov.</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>	
13. FATHER'S NAME <u>Geo. Pratt</u>				14. MOTHER'S MAIDEN NAME <u>Fannie B. Hazard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-24-2622</u>		17. INFORMANT <u>Reeve Pratt (son)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage + laceration</u> <u>976X</u> DUE TO (b) <u>bullet wound thru skull</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) <u>sudden</u>				INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Disorder due to consumption of drug</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Self-inflicted bullet wound thru skull</u>					
20c. TIME OF INJURY Month Day Year <u>12:01 p.m. 8-27 1958</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) <u>Silver Spring</u> (County) <u>Montgomery</u> (State) <u>md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>AUG. 29, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN CEMETERY</u>		22d. LOCATION (City, town, or county) <u>PRINCE GEORGE'S COUNTY, MD.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harner B. Pumphrey</u>				24a. REG'D BY REGISTRAR <u>AUG 29 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
ADDRESS <u>SILVER SPRING, MD.</u>				DATE			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1113. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 in the registrar prior to burial, cremation, or removal.

VS A15ME(5)
5M 9/55

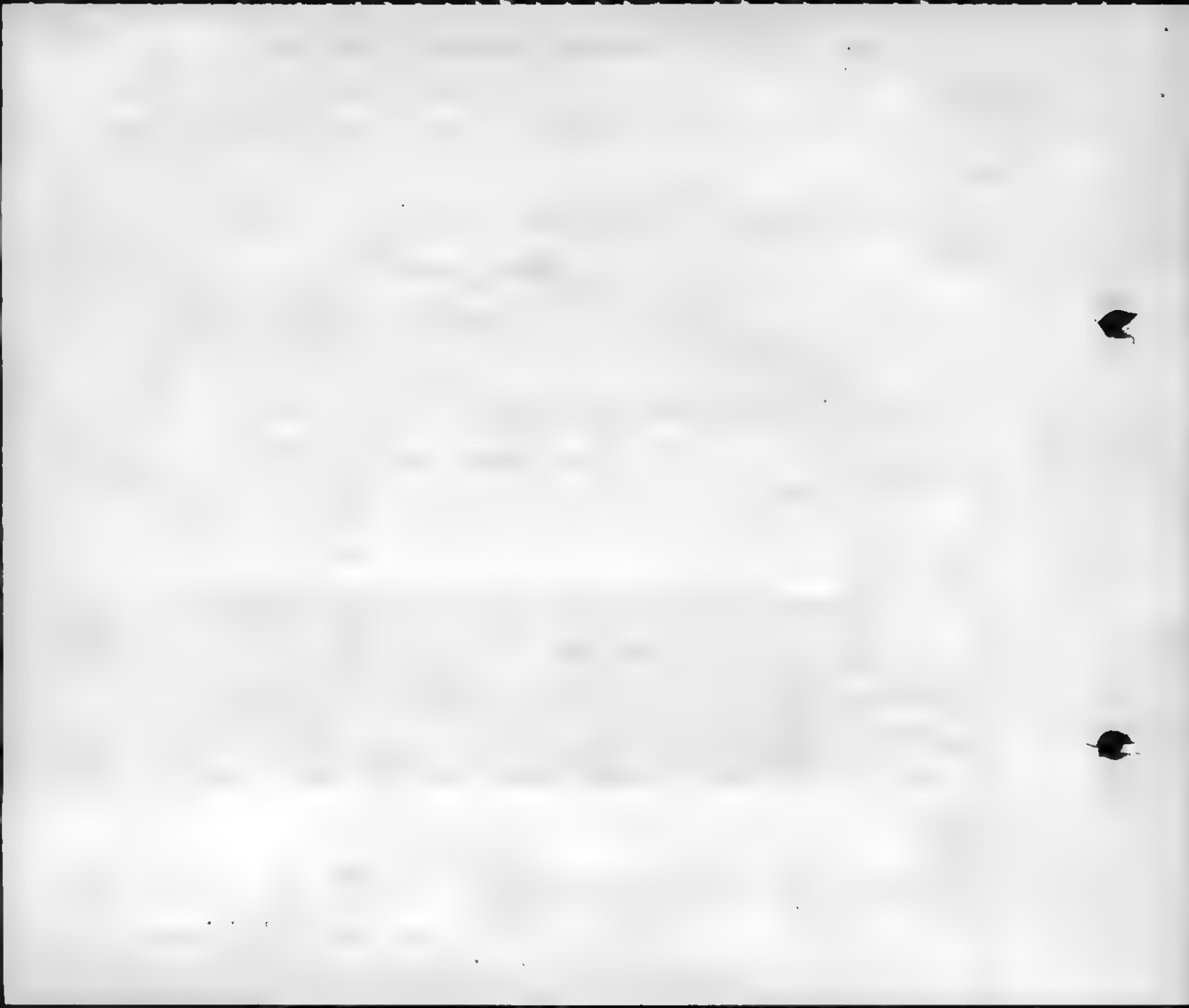
9191

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09298

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
c. LENGTH OF STAY IN 1b <u>D.O.A.</u>				d. STREET ADDRESS <u>8608 2nd Ave.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium + Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Eleanor Gilliland Preston</u>				4. DATE OF DEATH Month Day Year <u>8 - 4 1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-26-68</u> yrs.	
9. AGE (in years last birthday) <u>89</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Samuel Ball Fisher M.D.</u>				14. MOTHER'S MAIDEN NAME <u>Anella Bohe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Miss Phoebe Preston - Daughter</u> Address <u>Same address.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Boeschant</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Boeschant</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Aug 4 1958</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/7/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ROCK CREEK CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Danner B. Humphrey</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 6 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur</u>			



CERTIFICATE OF DEATH

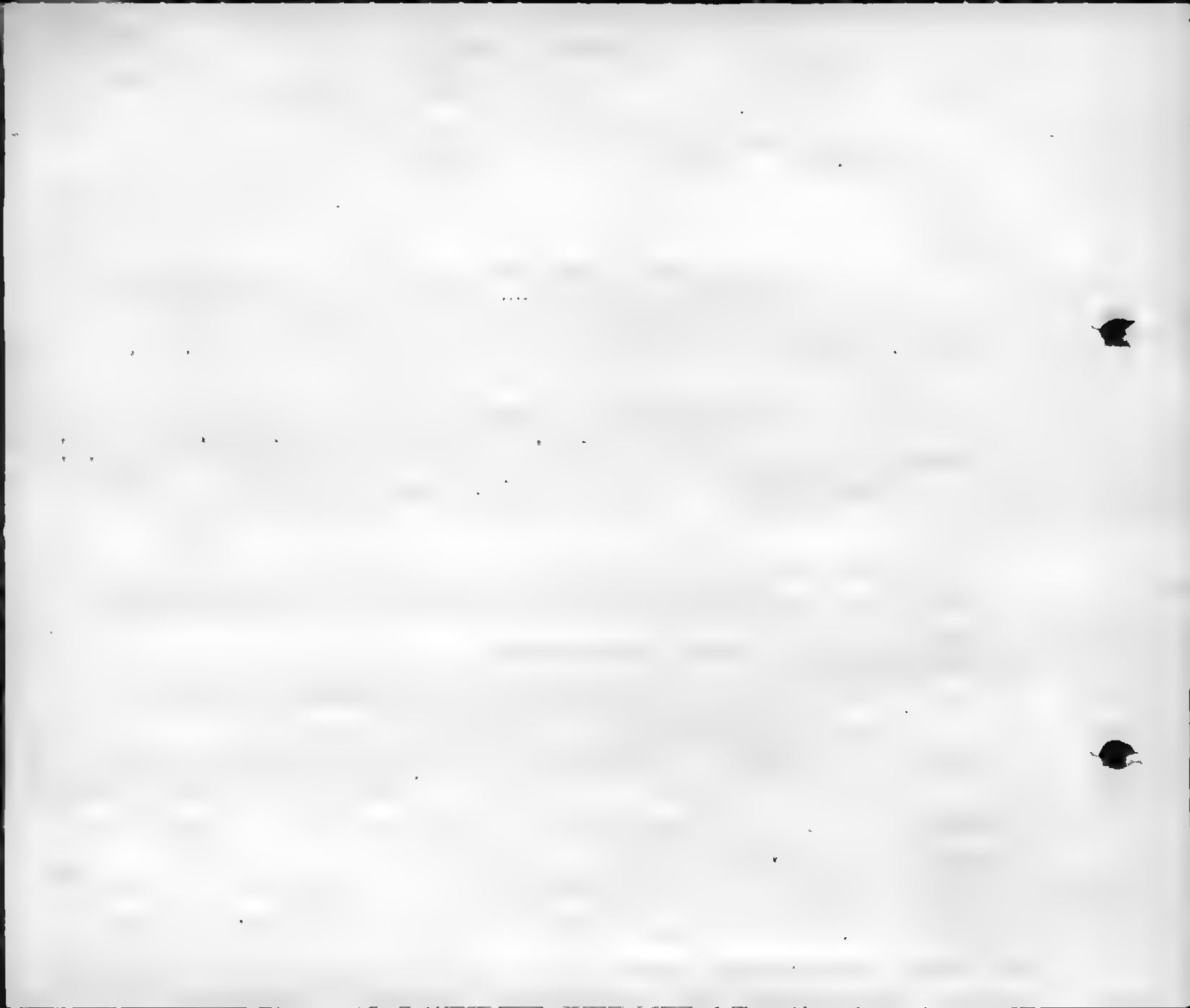
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Hall Sanitarium		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) RICHARD First POCHER Last		4. DATE OF DEATH AUG 15 1958 Month AUG Day 15 Year 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH -- 1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired- Surgeon		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 77 yrs. IF UNDER 1 YEAR: Months 77 Days 77 Hours 77 Min. IF UNDER 24 HRS
11. BIRTHPLACE (State or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Mabel Benson Sakis-Wash. Loan & Tr. Bldg Washington, D.C.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c) ESSENTIAL HYPERTENSION			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from FEB. 11, 1958 to AUG. 15, 1958 , that I last saw the deceased alive on AUG. 15, 1958 , and that death occurred at 3:15 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Henry M. Lowden M.D.		ADDRESS (Street, city or town, state) 5206 NORWAY DR. DATE SIGNED	
PHYSICIAN'S NAME (Type) Henry M. Lowden		CHERYL CHASE, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/19/1958	22c. NAME OF CEMETERY OR CREMATORY Ivy Hill Cemetery	22d. LOCATION (City, town, or county) (State) Alexandria, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co 2901-14th St N.W. Wash D.C.		24a. REC'D BY REGISTRAR AUG 18 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Hines

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: As this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy, and in any event within 72 hours after death, the registrar prior to burial, cremation, or removal.



9309

CERTIFICATE OF DEATH

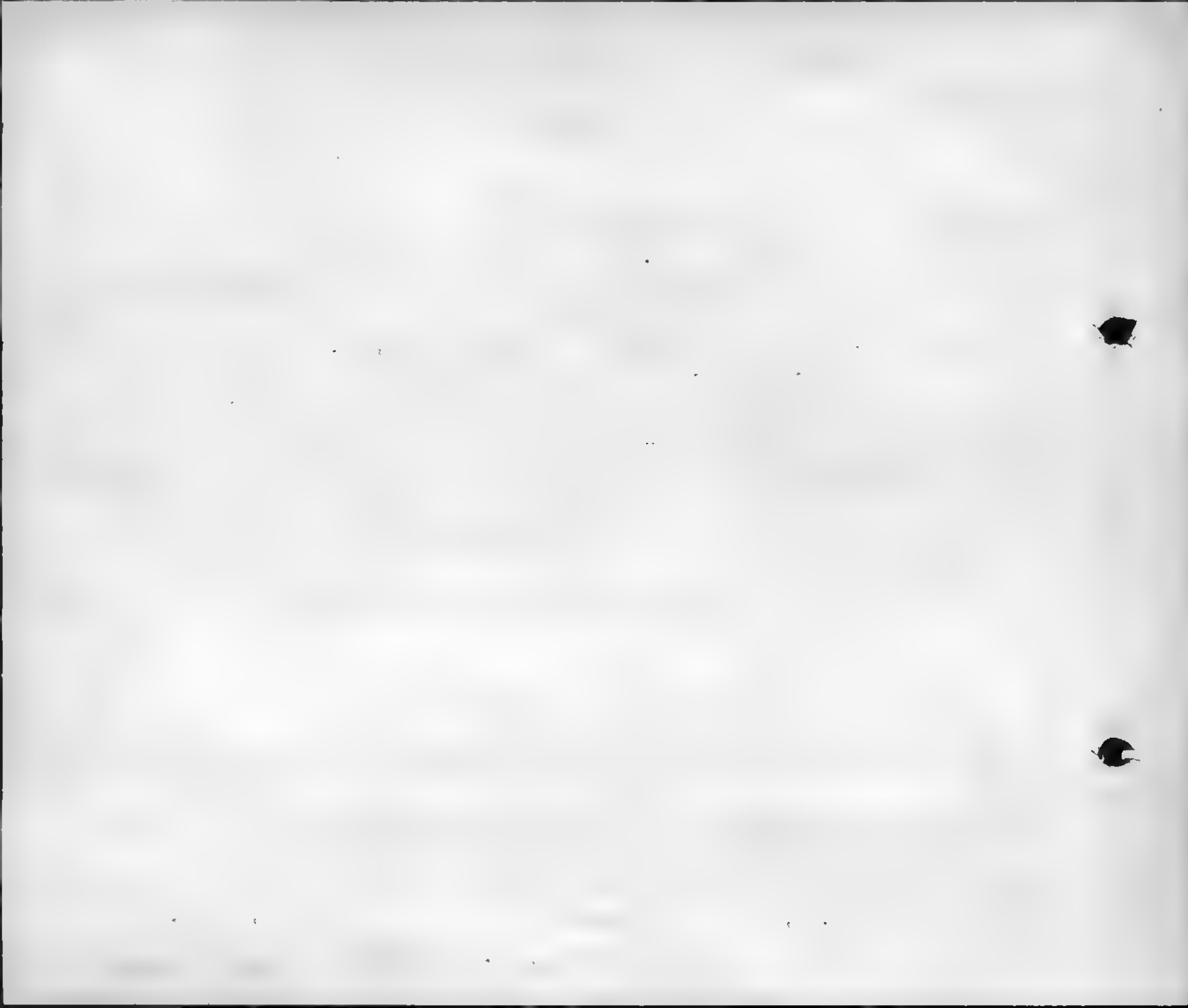
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9127 SECOND AVENUE</u>		d. STREET ADDRESS <u>19107 SECOND AVENUE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>HARVEY</u> Middle <u>M.</u> Last <u>RAGSDALE</u>		4. DATE OF DEATH Month <u>AUGUST</u> Day <u>18</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 4, 1875</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Lock Haven, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>JOHN N. GAST</u>		14. MOTHER'S MAIDEN NAME <u>HARRIET S. MEYERS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>577-03-4467</u>	
17. INFORMANT <u>WILSON RAGSDALE</u>		Address <u>403 WHITESIDE ROAD SILVER SPRING, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> <u>410X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>MITRAL INSUFFICIENCY</u> DUE TO (c) <u>-</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 MOS.</u> <u>3 YEARS.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct. 10, 1957</u> , to <u>AUGUST 18, 1958</u> , that I last saw the deceased alive on <u>AUGUST 18, 1958</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <u>DANIELA ROBERTS</u> M.D. <u>5707 GEORGIA AVE SILVER SPRING, MD</u>		<u>AUG. 18, 1958</u>	
PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug. 22, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Highland Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Lock Haven, Penna.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>WILLIAM G. LIMPURCH</u>		ADDRESS <u>Silver Spring, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>AUG 22 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 2 and 3 and return them to the registrar prior to burial, cremation, or removal, and in any event within 48 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and use as the burial-transit permit. Then please remove carbon and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9192

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jakoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jakoma Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7803 Lockney Avenue</u>				d. STREET ADDRESS <u>1 7803 Lockney Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>EDWARD</u> Middle <u>F.</u> Last <u>READ</u>				4. DATE OF DEATH Month <u>August</u> Day <u>18</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 19, 1890</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u>18</u> Days <u>18</u> Hours <u>18</u> Min. <u>18</u>		IF UNDER 24 HRS. Months <u>18</u> Days <u>18</u> Hours <u>18</u> Min. <u>18</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Security Man</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Had Shoppers</u>			
11. BIRTHPLACE (State or foreign country) <u>Philadelphia, Pa.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Theodore Read</u>				14. MOTHER'S MAIDEN NAME <u>Not Available</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give year or dates of service) <u>W.W.I.</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Mrs. Huldah P. Read</u>				Address <u>(Same as #2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 RESPIRATORY FAILURE</u> DUE TO (b) <u>MYOCARDIAL INEARTHCTION</u> DUE TO (c) <u>CORONARY ARTERY DISEASE</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. <u>24 HRS.</u> INTERVAL BETWEEN ONSET AND DEATH <u>3-4 HRS.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>9</u> p. m. Month <u>19</u> Day <u>19</u> Year <u>1958</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>7/11</u> , 19 <u>58</u> , to <u>8/18</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8/16</u> , 19 <u>58</u> , and that death occurred at <u>1:00 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Harold Sterling</u>				ADDRESS (Street, city or town, state) <u>1352 UNIVERSITY AVE NW WYATTSVILLE, MD.</u>			
DATE SIGNED <u>8/18/58</u>							
PHYSICIAN'S NAME (Type) <u>HAROLD STERLING</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 20, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Hall Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters, 254 Carroll Park Dr. S.C.</u>				24. REC'D BY REGISTRAR <u>AUG 20 58</u>			
ADDRESS <u>254 Carroll Park Dr. S.C.</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			



9193

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>PRINCE GEORGE'S</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <u>LAKOTA PARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON SANITARIUM + HOSP.</u>		d. STREET ADDRESS <u>3103 NICHOLSON ST.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET JANE REEVES</u>		4. DATE OF DEATH Month Day Year <u>AUGUST 16 1958</u>	
5. SEX <u>FE</u>	6. COLOR OR RACE <u>WH</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-8-05</u>
9. AGE (In years lost birthday) <u>53</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HSWF.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	11. BIRTHPLACE (State or foreign country) <u>SCOTLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>CANADA</u>		13. FATHER'S NAME <u>JOHN MURDOCH</u>	
14. MOTHER'S MAIDEN NAME <u>MARGARET COCHRANE</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Records</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adrenal insufficiency</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Post-operative Subtotal Hysterectomy</u> DUE TO (c) <u>Obstructive Duodenal ulcer</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>48 hours</u> <u>3 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>August 12, 1958</u> to <u>August 16, 1958</u> , that I last saw the deceased alive on <u>August 16, 1958</u> , and that death occurred at <u>4:50 A.M.</u> from the causes and on the date stated above.		
ACTUAL SIGNATURE <u>Lyle Williams</u> M.D.		ADDRESS (Street, city or town, state) <u>8700 Calverville Rd. Silver Spring, Md.</u>
PHYSICIAN'S NAME (Type) <u>Lyle Williams M.D.</u>		DATE SIGNED <u>Aug 16, 1958</u>
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug. 18, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>George Washington Cemetery</u>
22d. LOCATION (City, town, or county) (State) <u>Prince Geo. Co. Maryland</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u> ADDRESS <u>254 Carroll Ave. D.C.</u>
24a. REC'D BY REGISTRAR DATE <u>AUG 19 1958</u>		24b. REGISTRAR'S SIGNATURE <u>John S. H. S.</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, 3 should be detached and used as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9202

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	c. LENGTH OF STAY IN 1b 5 Years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 26 Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1622 Burris Rd.		d. STREET ADDRESS 1622 Burris Rd.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ERNEST Middle B. RENNINGER Last		4. DATE OF DEATH Month Aug. 3, Day 19 Year 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 29, 1916
9. AGE (In years last birthday) 41 yrs.		IF UNDER 1 YEAR Months 7 Days 4 Hours Min. 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Photographer		10b. KIND OF BUSINESS OR INDUSTRY Gov't	11. BIRTHPLACE (State or foreign country) Boyertown, Pa.
13. FATHER'S NAME Ernest B. Renninger		14. MOTHER'S MAIDEN NAME Florence Bird	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 185-05-1550	17. INFORMANT Wife Address Same as Item 2.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary insufficiency DUE TO and Angina Pectoris (c) 		INTERVAL BETWEEN ONSET AND DEATH 15 min 4 1/2 yrs 4 1/2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from February 4, 1957 , to 3 Aug. 1958 , that I last saw the deceased alive on 12 July 1958 , and that death occurred at 2:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. G. Hall		ADDRESS (Street, city or town, state) DATE SIGNED 615 W. Montgomery Ave. Rockville, Md. 8-358	
PHYSICIAN'S NAME (Type) W. G. Hall		M.D. 615 W. Montgomery Ave. Rockville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-5-58	22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cem.	22d. LOCATION (City, town, or county) (State) Arlington, Virginia.
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR DATE AUG 5 '58		24b. REGISTRAR'S SIGNATURE W. G. Hall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, it shall be filled in by the funeral director, page 3 should be detached from this page as the burial-transit permit. Then please remove carbon paper between Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9194

CERTIFICATE OF DEATH

09304

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park Md</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Commonwealth Hospital</u>			d. STREET ADDRESS <u>2818 Spencer Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Herbert</u> Middle <u>Henry</u> Last <u>Rice</u>			4. DATE OF DEATH Month <u>August</u> Day <u>14</u> Year <u>1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-16-99</u>	9. AGE (In years lost birthday) <u>59</u> yrs	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney at Law - Dept. of Defense</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't.</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S. Status</u>			13. FATHER'S NAME <u>Henry J. Rice</u>		
14. MOTHER'S MAIDEN NAME <u>Annie Atwell</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW-II</u>		
16. SOCIAL SECURITY NO			17. INFORMANT Address <u>Cherry Chase, Md.</u> <u>Mrs. Vera C. Rice - 2818 Spencer Rd.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]					INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Gastric Intoxication</u>					<u>12 hrs</u>
DU TO (b) <u>Supra-pubic prostatic</u>					<u>3 1/2 days</u>
DU TO (c) <u>Coronary Heart Disease</u>					<u>10-15 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>8-8-58</u> to <u>8-14-58</u> , that I last saw the deceased alive on <u>8-14-58</u> 19 <u>58</u> , and that death occurred at <u>11:18</u> M., from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Oliver E. Thompson</u> M.D.			ADDRESS (Street, city or town, state) <u>1835 Eye St. N.W.</u> DATE SIGNED <u>Wash. D.C.</u>		
PHYSICIAN'S NAME (Type) <u>Oliver E. Thompson</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/18/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cem. Arlington, Virginia</u>	
22d. LOCATION (City, town, or county) (State)		23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
The S. H. Hines Company-Washington, DC		ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hunt</u>	
DATE <u>AUG 18 '58</u>					



9310

CERTIFICATE OF DEATH

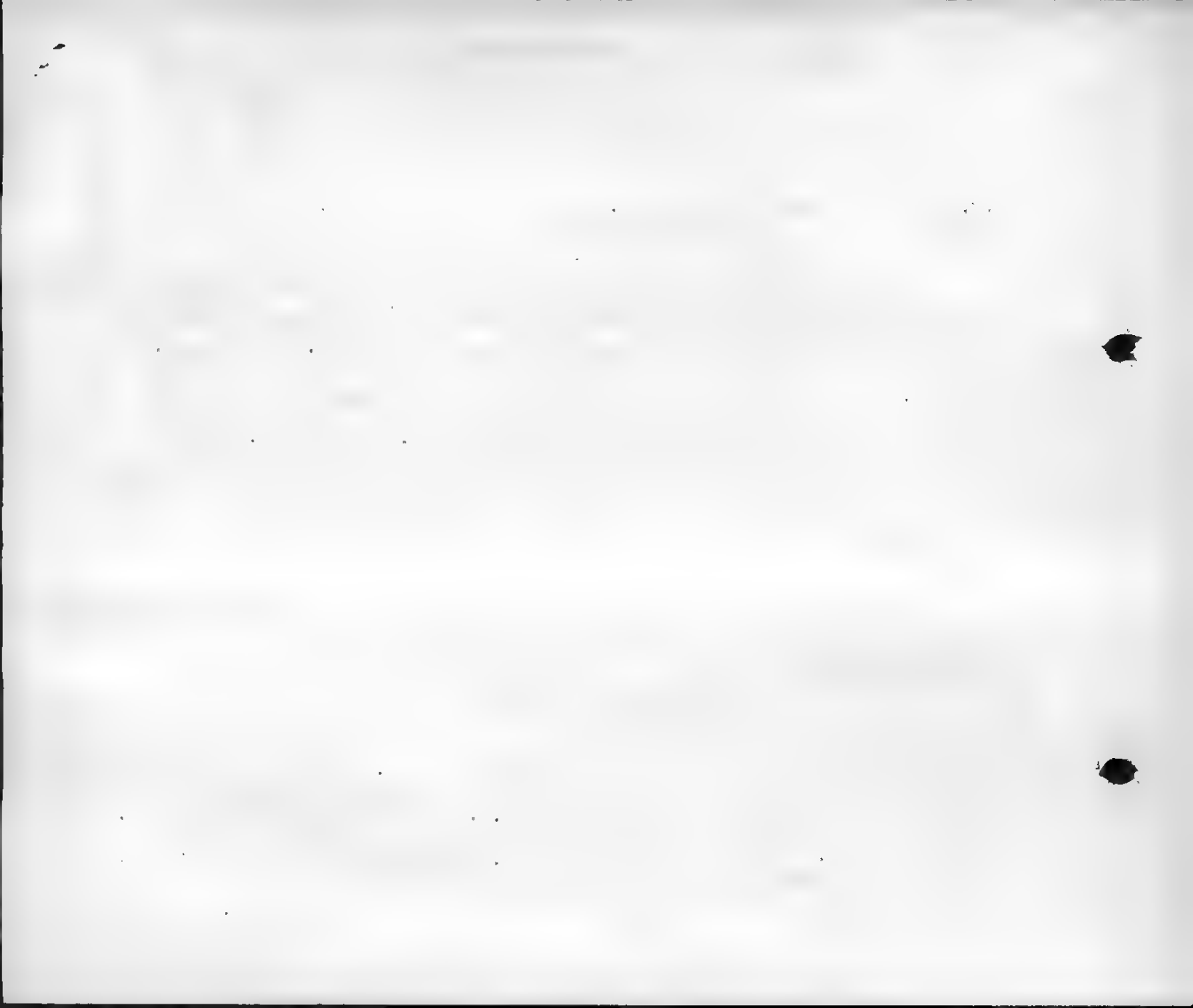
10395

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>	
c. LENGTH OF STAY IN 1b <u>3 days</u>		d. STREET ADDRESS <u>2418 Lake Ave.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Bethesda, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Pearl</u> Middle <u>Proffit</u> Last <u>RIDLEY</u>		4. DATE OF DEATH Month <u>August</u> Day <u>24</u> Year <u>19 58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>29 March 1887</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Prince Edward Isa. Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James H. Proffit</u>		14. MOTHER'S MAIDEN NAME <u>Charlotte Crozier</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>12-26-5735</u>	
17. INFORMANT <u>(Daughter) Mrs. Charlotte R. Walkins (Same As #2)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular occlusion</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) <u> </u>			
INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>21 August</u> , 19 <u>58</u> , to <u>24 August</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>24 August</u> , 19 <u>58</u> , and that death occurred at <u>12:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James M. Young, M.D.</u>		ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Bethesda, Md.</u>	
PHYSICIAN'S NAME (Type) <u>James M. Young, LT, MC, USN</u>		DATE SIGNED <u>8-25-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-29-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Forrestdale Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Holyoke, Mass.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis Gasch & Sons, Hyattsville, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 26 '58</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9311

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09305

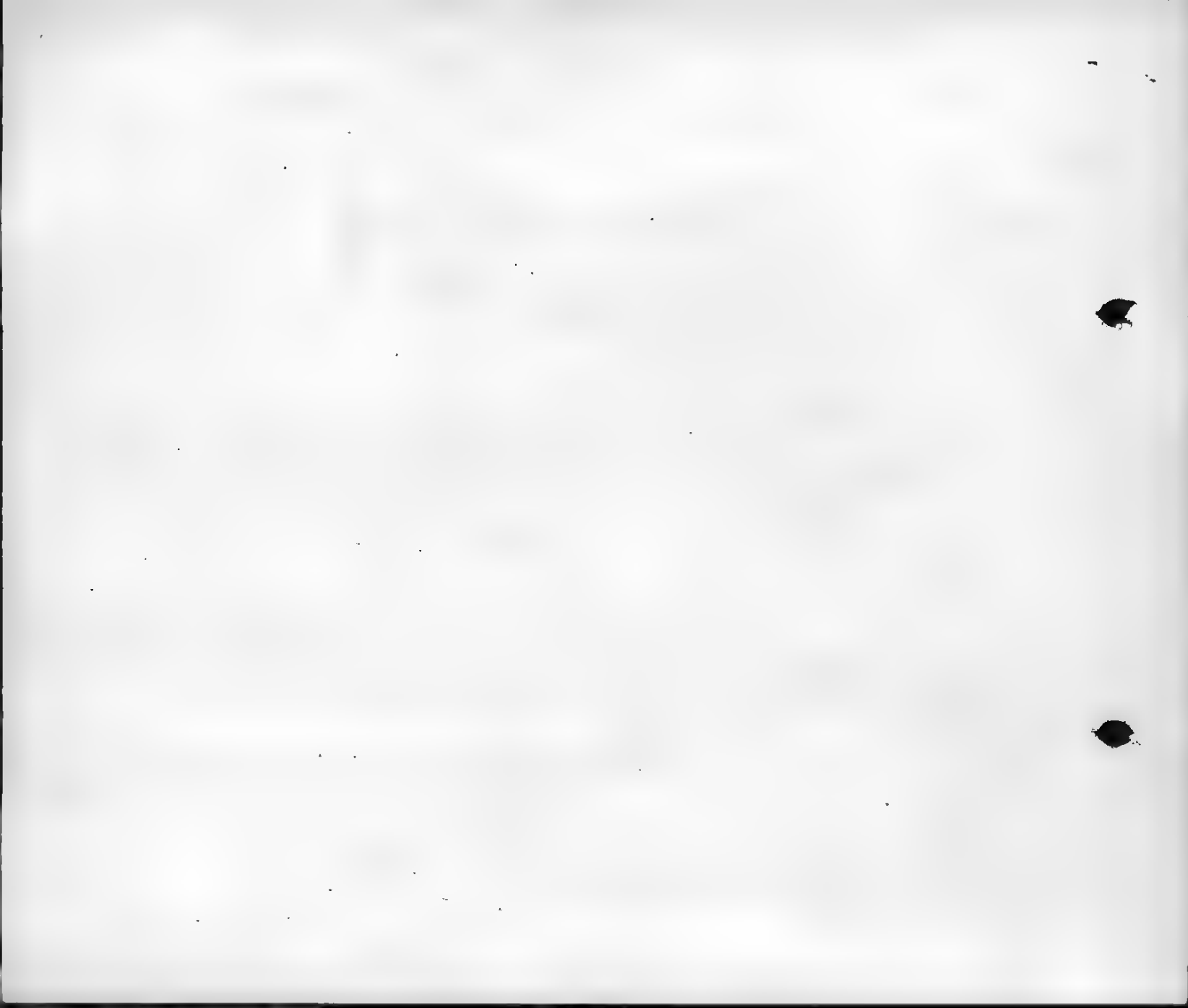
Items 8 & 9, Film G-233 9/11/58

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capital Heights	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 14511 COLESVILLE RD. NURSING HOME		d. STREET ADDRESS 208 6th Place	
3. NAME OF DECEASED (Type or print) MARY W. ROBBINS		4. DATE OF DEATH August 11 1958	
5. SEX FEMALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH NOV 2, 1894
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY ENGLAND	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME JAMES WILKINSON		14. MOTHER'S MAIDEN NAME MARY A. BIDDLE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO NONE	
17. INFORMANT MABEL A. PHINNEY		18. ADDRESS 4333 N. 2ND AVE PHOENIX, ARIZONA	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Thrombosis		5 hrs	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Corbary Disease		years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial Infarction		2 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 4, 1958 to Aug 11, 1958 , that I last saw the deceased alive on Aug 11, 1958 , and that death occurred at 5:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Arthur S. Frank M.D.		ADDRESS (Street, city or town, state) 1219 - Louisiana St S.E. 11-58	
DATE SIGNED Aug 11 1958		PHYSICIAN'S (Type) Physician	
22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8-15-58	
22c. NAME OF CEMETERY OR CREMATORY GLENNWOOD CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co. Inc. ADDRESS Washington, D.C.		24a. REC'D BY REGISTRAR DATE AUG 13 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached from the certificate as the burial-transit permit. Then please remove carbon copy of the certificate and return it to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9312

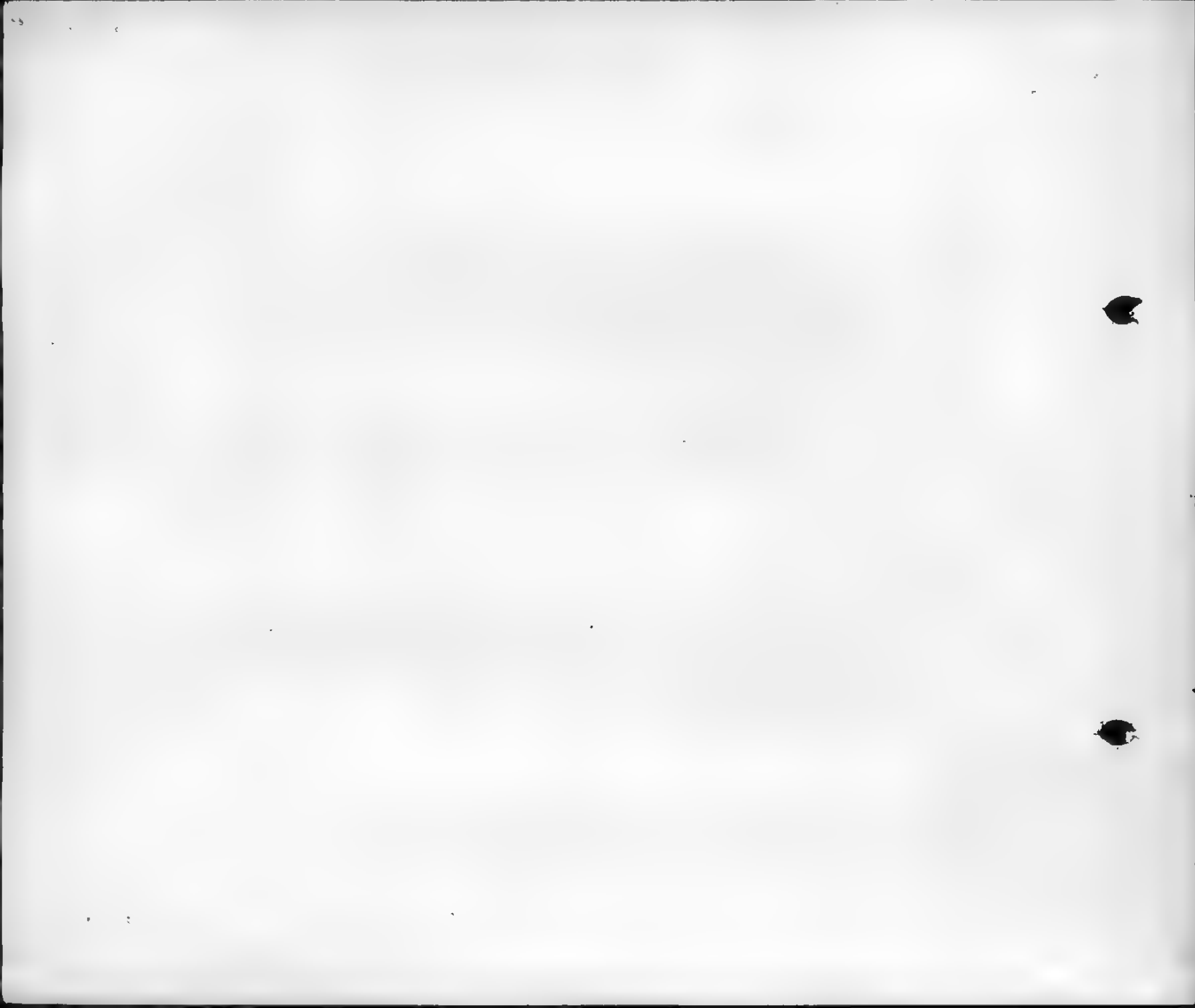
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Ezra Ross</u>		4. DATE OF DEATH <u>Aug 2 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 3 1894</u>
9. AGE (In years last birthday) <u>64</u> yrs		10. UNDER 1 YEAR <u>0</u> Months <u>29</u> Days <u></u> Hours <u></u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor of Sales</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Rubber Co. Mass.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Ross</u>		14. MOTHER'S MAIDEN NAME <u>Mary ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>yes-unknown</u>	
17. INFORMANT <u>Mrs. Lillian Ross - same</u>		Add <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>M. VASCULAR HEART DISEASE</u> DUE TO <u>ARTERIO SCLEROTIC HEART DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>None</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/1</u> , 19 <u>58</u> , to <u>8/2</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8/2</u> , 19 <u>58</u> , and that death occurred at <u>10:28 AM</u> , from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Charles J. Furman, M.D.</u>		ADDRESS (Street, city or town, state) <u>4505 Eastway, Bethesda, Md.</u>	
DATE SIGNED <u>Aug 4 1958</u>			
PHYSICIAN'S NAME (Type) <u>CHARLES J. FURMAN, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-6-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. A. Pennington Funeral Home</u>		ADDRESS <u>7537 Wisconsin Ave Bethesda, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE AUG 5 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon copy of the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9313

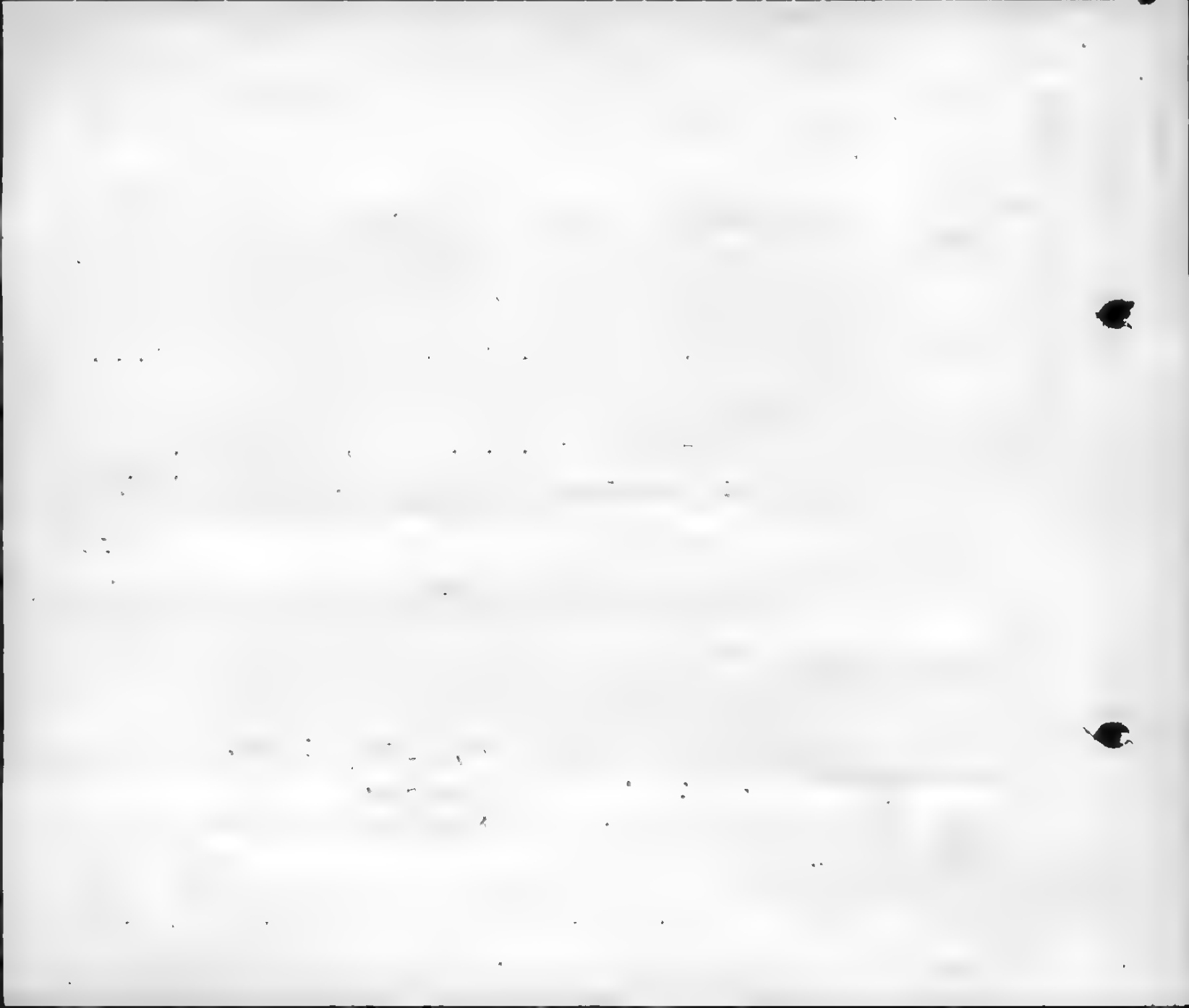
CERTIFICATE OF DEATH

09307

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN 1b 20 years		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8803 2nd Avenue		d. STREET ADDRESS 8803 2nd Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First OLIVER Middle C Last SABIN		4. DATE OF DEATH Month AUGUST Day 6 Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/31/74
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months 7 Days 3 Hours 15 Min 00	IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer & Painter		10b. KIND OF BUSINESS OR INDUSTRY Wash. Gas Light Co.	
11. BIRTHPLACE (State or foreign country) Nebraska		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Corwin Sabin		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 577-07-9148	
17. INFORMANT Mrs. F. L. Goodwin		Address 8803 2nd Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory Collapse, low blood pressure 300.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senility DUE TO (c) Dementia Praecox		INTERVAL BETWEEN ONSET AND DEATH 2 days 10 weeks 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 0 m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan, 1948 to Aug 6, 1958 , that I last saw the deceased alive on Aug 5, 1958 , and that death occurred at about 2:20 PM from the causes and on the date stated above.			
ACTUAL SIGNATURE Frank G. Leslie		ADDRESS (Street, city or town, state) 8901 Ba Dr Silver Spring Md DATE SIGNED Aug 6, 58	
PHYSICIAN'S NAME (Type) FRANK G. LESLIE			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 8/8/58	22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY	22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MD.
23. FUNERAL DIRECTOR'S SIGNATURE Wanner E. Humphrey		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR DATE AUG 8 '58		24b. REGISTRAR'S SIGNATURE W. H. Beach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached (use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

215.

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 4 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY M	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, NMMC, Bethesda, Md.				d. STREET ADDRESS Circle Drive, Glenn Hills				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John		Middle Leonard		Last SCHAEFER		4. DATE OF DEATH Month August		Day 17	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6 May 1871		9. AGE (In years last birthday) 87 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Special police Officer		10b. KIND OF BUSINESS OR INDUSTRY Bellman Brook Paper Company		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Leonard SCHAEFER				14. MOTHER'S MAIDEN NAME Christine (Last name unknown)					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT (Daughter) Aneete HALL		Address (Same as #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, Generalized DUE TO (c) Cerebral Arteriosclerosis								INTERVAL BETWEEN ONSET AND DEATH years years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) U.S. Naval Hospital, Bethesda Md.		(County) (State)	
21. I certify that I attended the deceased from 13 August , 19 58 , to 17 August , 19 58 , that I last saw the deceased alive on 17 August , 19 58 , and that death occurred at 1230 P.M. , from the causes and on the date stated above.									
ACTUAL SIGNATURE <i>Michael Miale Jr.</i>		DATE SIGNED U.S. Naval Hospital, Bethesda Md. 8-17-58							
PHYSICIAN'S NAME (Type) A. MIALE JR. LT MC USN		U.S. Naval Hospital, Bethesda Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-21-58		22c. NAME OF CEMETERY OR CREMATORY George Washington Memorial		22d. LOCATION (City, town, or county) (State) Park Paramus New Jersey			
23. FUNERAL DIRECTOR'S SIGNATURE <i>The S.H. Hines Co.</i> S.H. HINES, 2901 14th Street N.W. Washington D.C.				24a. REC'D BY REGISTRAR AUG 19 58		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon pages 1 and 2 should be buried with the registrant prior to burial, cremation, or removal, and in any event within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9316

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09310

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>		c. LENGTH OF STAY IN 1b <u>10 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Chevy Chase</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6812 Delaware Street</u>			d. STREET ADDRESS <u>6812 Delaware Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>MILTON</u> Middle <u>C</u> Last <u>SCHERR</u>			4. DATE OF DEATH Month <u>August</u> Day <u>16</u> Year <u>19 58</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 4, 1884</u>		9. AGE (In years last birthday) <u>74</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stott Pub. Co-Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>
13. FATHER'S NAME <u>Julius Sherr</u>			14. MOTHER'S MAIDEN NAME <u>Emale Sievers</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>298-07-4977</u>	17. INFORMANT <u>Henry L Sherr, brother, same as 2d</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arterio sclerosis</u> DUE TO (c)					INTERVA. BETWEEN ONSET AND DEATH <u>7 1/2 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>NO</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>p. m.</u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>John G. Ball</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>16 Aug 1958</u>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>	22b. DATE THEREOF <u>8/19/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>East Oak Grove</u>		22d. LOCATION (City, town, or county) (State) <u>Morgantown, W. Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>AUG 19 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9195

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

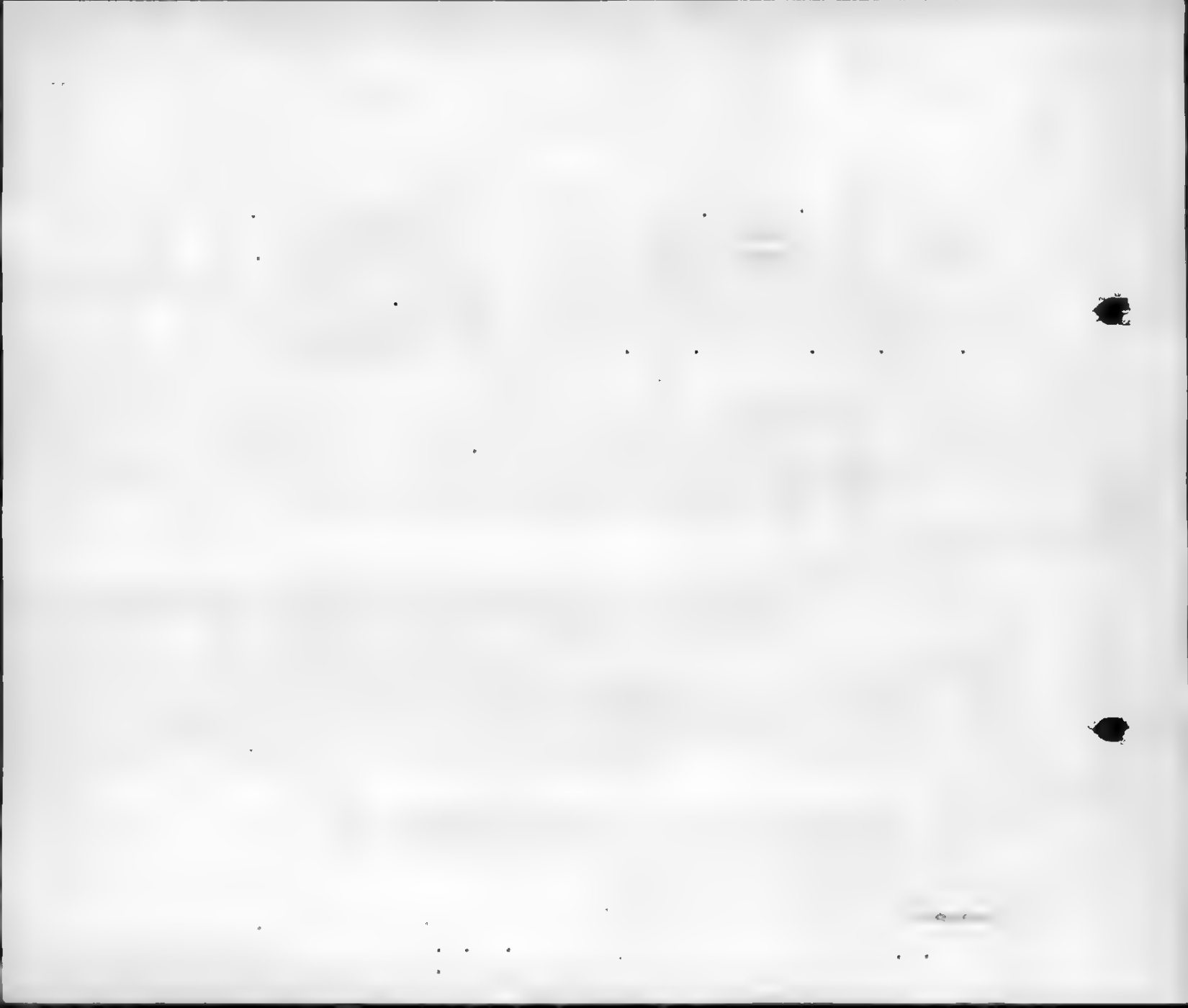
09311

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 should be retained for your files. TO FUNERAL DIRECTOR: Pages 1 and 2 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park	c. LENGTH OF STAY IN 1b Takoma Park		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7620 Maple Ave. Apt. 436		d. STREET ADDRESS 7620 Maple Ave Apt. 436	
3. NAME OF DECEASED (Type or print) James Emmett Shea		4. DATE OF DEATH Aug. 8, 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/23/1896.
9. AGE (In years, month, day, hour) 61 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bldg. Contr. (ret.)		11b. KIND OF BUSINESS OR INDUSTRY Gen. Bldg. Trades	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Bernard Shea		14. MOTHER'S MAIDEN NAME Mary Ann Welch	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Eva F. Shea		Address same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. (c)			INTERVAL BETWEEN ONSET AND DEATH sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/11/58	
22c. NAME OF CEMETERY OR CREMATORY Beahm's Chapel Com.		22d. LOCATION (City, town, or county) (State) Luray, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Company		24a. REC'D BY REGISTRAR 2901 14th St. N.W. Washington 9, D.C.	
		24b. REGISTRAR'S SIGNATURE Aug 11 '58	



9317

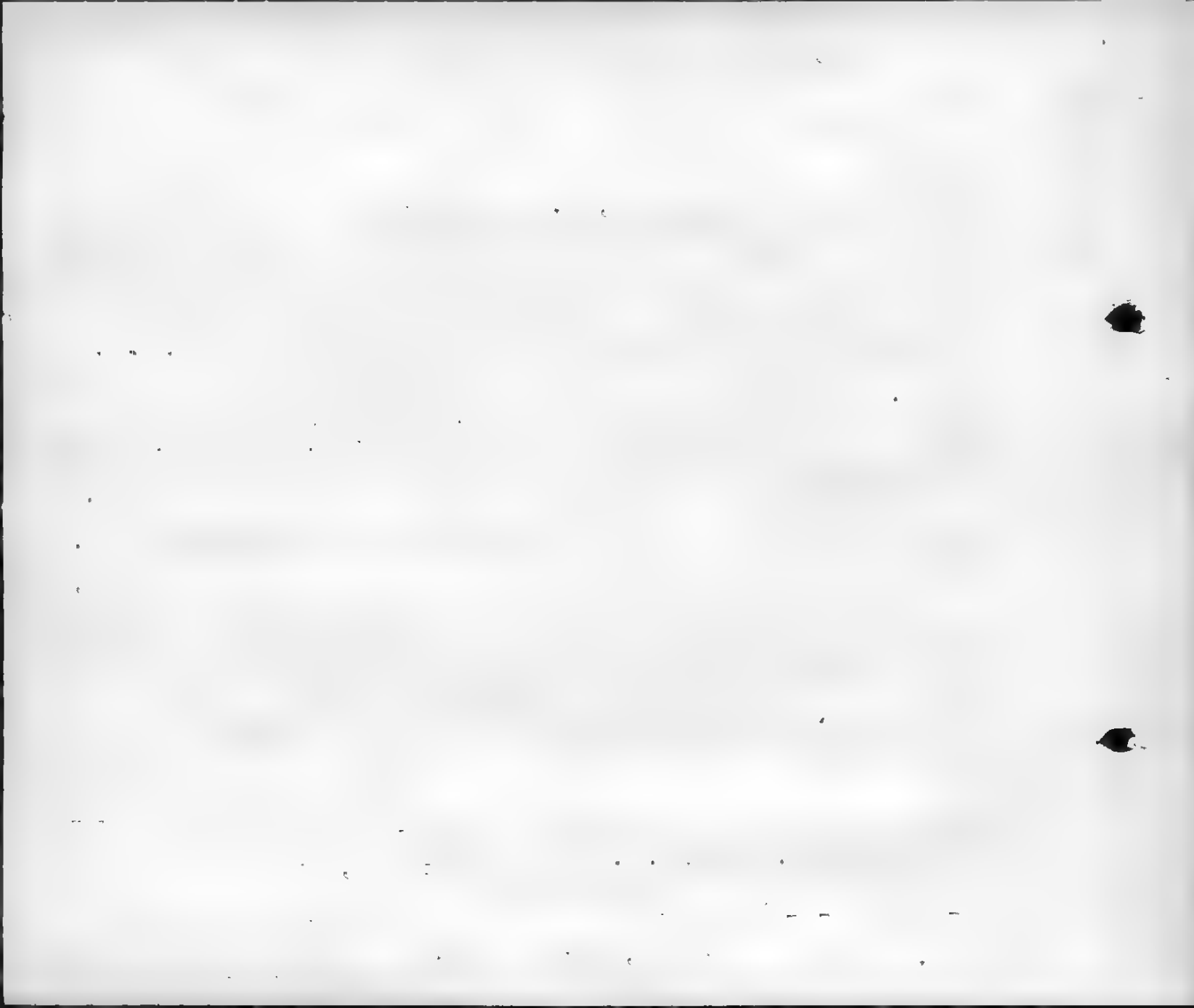
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE West Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 88 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Wiley Middle Edward Last Shrewsbury		4. DATE OF DEATH Month August Day 8 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 21, 1898
9. AGE (In years last birthday) 60 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY Mining	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry W. Shrewsbury		14. MOTHER'S MAIDEN NAME Annie Munsey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unascertainable	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Silicosis & pulmonary reticulum cell sarcoma 1 yr. DUE TO (c) Reticulum cell sarcoma 1 yr.			INTERVAL BETWEEN ONSET AND DEATH 1 wk.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 12, 1958 , to August 8, 1958 , that I last saw the deceased alive on August 8, 1958 , and that death occurred at 9:43 A. from the causes and on the date stated above.			
ACTUAL SIGNATURE Nathan S. Taylor		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) Nathan S. Taylor, M. D.		DATE SIGNED 8-8-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit	22b. DATE THEREOF 8-12-58	22c. NAME OF CEMETERY OR CREMATORY Matoka	22d. LOCATION (City, town, or county) (State) Matoka, West Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		24a. REC'D BY REGISTRAR AUG 12 1958	
ADDRESS Bethesda, Maryland		24b. REGISTRAR'S SIGNATURE Arthur S. Kroug	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached, cause of the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filled with the information, or removal, and in any event within 72 hours after death.



9318

CERTIFICATE OF DEATH

09313

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <u>D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Alta Vista Rest Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jennie Carter Simon</u>				4. DATE OF DEATH Month Day Year <u>Aug 28 1958</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 10, 1888</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		10. UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <u>William Carter</u>				14. MOTHER'S MAIDEN NAME <u>Jennie Gifford</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO			
17. INFORMANT <u>Mrs. Jennie Carter Simon</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolisation</u> 426X DUE TO (b) <u>Phlebothrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>7/21</u> , 1958, to <u>8/28</u> , 1958, that I last saw the deceased alive on <u>8/28</u> , 1958, and that death occurred at <u>7:55 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Prokopos Colevas</u>				DATE SIGNED <u>1120 16th St NW Washington DC 9/28/58</u>			
PHYSICIAN'S NAME (Type) <u>Prokopos Colevas</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>9/2/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem. Ft. Myer, Va.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co. Washington 9, D.C.</u>				24a. REC'D BY REGISTRAR <u>SEP 2 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kinnel</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9319

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> LENGTH OF STAY IN 1b <u>2 1/2 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2728 RANDOLPH ROAD</u>		d. STREET ADDRESS <u>1 2728 RANDOLPH ROAD</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>De Witt Talmadge Smith</u>		4. DATE OF DEATH Month <u>8</u> Day <u>10</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/14/95</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant - Gen. Accounting U.S. Gov't.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NORTH CAROLINA</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ABRAHAM LINCOLN SMITH</u>		14. MOTHER'S MAIDEN NAME <u>LULA BROWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WW # 1 & 2</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT Address <u>Mrs. Nina Pearl Smith, 2728 Randolph Road Silver Spring, Maryland</u>		18. INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>			
440.0 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary occlusion</u>			
DUE TO (c) <u>Arteriosclerotic heart disease</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>None</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/28/58</u> , 19 <u>58</u> , to <u>8/10</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8/10</u> , 19 <u>58</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>8805 Conn. Ave.</u>		DATE SIGNED <u>8/10/58</u>	
ACTUAL SIGNATURE <u>John B. Umhan</u> M.D.			
PHYSICIAN'S NAME (Type) <u>JOHN B. UMHAN Chevy Chase 15 Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>8/13/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner B. Humphrey</u> ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>AUG 12 1958</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Tracy</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and is hereby certified to be true and correct. Page 3 should be detached and used as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO FUNERAL DIRECTOR: All of this certificate has been signed by the attending physician and is completely filled in by the funeral director. Page 3 should be detached and used as the burial-transit permit. Then please remove carbon and return to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9320

CERTIFICATE OF DEATH

09315

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>5 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Fanny Gertrude Smith</u>				4. DATE OF DEATH Month Day Year <u>Aug 24 1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 29, 1873</u>	9. AGE (In year, last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
13. FATHER'S NAME <u>James Mereness</u>				14. MOTHER'S MAIDEN NAME <u>Richardson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				17. INFORMANT Address <u>William F Smith, 9232 Villa Dr. Bethesda, Md.</u>			
16. SOCIAL SECURITY NO. <u>—</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Intestinal Bleeding</u> DUE TO <u>CA gastric</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CA gastric</u> DUE TO (c) <u>CA</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CA Rectum & Bladder</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>get</u> 19 <u>50</u> , to <u>24 Aug. 1958</u> , that I last saw the deceased alive on <u>24 Aug. 1958</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>615 W. Montgomery and Rockwell Rd. Bethesda, Md.</u> DATE SIGNED <u>Aug 26 1958</u>							
ACTUAL SIGNATURE <u>Wm. S. Murphy</u>				PHYSICIAN'S NAME (Type) <u>Wm. S. Murphy</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>8/25/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert A. Pumphrey-Bethesda, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 26 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	



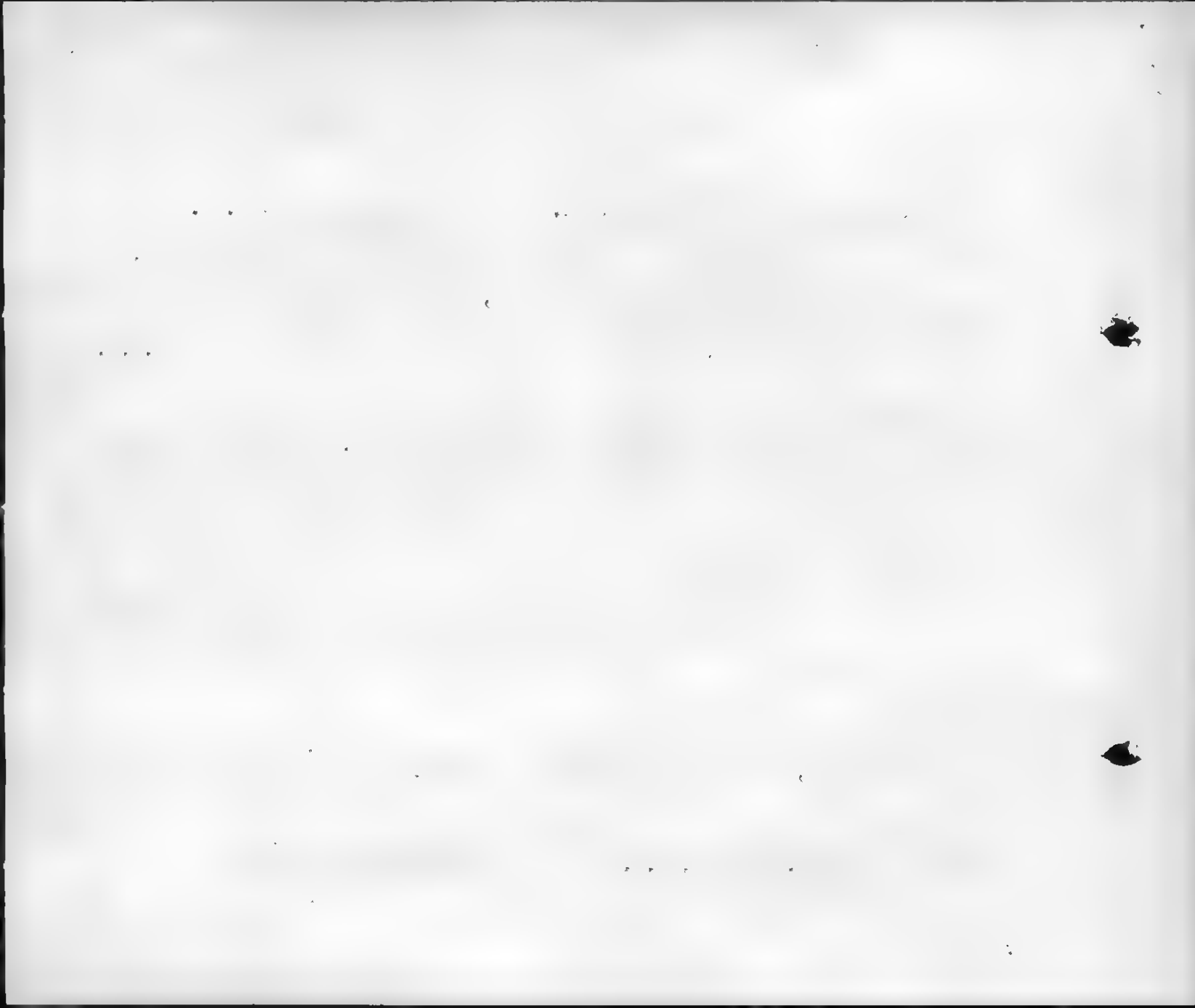
9321

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 42 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. STREET ADDRESS 6404 Buchanan Street, N. E.			
3. NAME OF DECEASED (Type or print) First Middle Last Raymond William Snyder				4. DATE OF DEATH Month Day Year August 25, 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 20, 1906	
9. AGE (In years last birthday) 52 yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Offset Plate Maker				10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) New Jersey	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William Snyder				14. MOTHER'S MAIDEN NAME Ida Roberts			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) Yes WW II				16. SOCIAL SECURITY NO. unknown		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 292.4 Abscess of Left Temporal lobe of brain DUE TO (b) Staphylococcal Septicemia DUE TO (c) Aplastic anemia CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1 week 2 weeks 1 year							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 14, 19 58 to August 25, 19 58 , that I last saw the deceased alive on August 25, 19 58 , and that death occurred at 12:25 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Peter S. Mueller, M.D. M.D.				ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland			
DATE SIGNED 8/25/58							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial							
22b. DATE THEREOF 8-29-58							
22c. NAME OF CEMETERY OR CREMATORY Hawthorne Nat'l.							
22d. LOCATION (City, town, or county) (State) FT MYER, Va.							
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers				24a. REC'D BY REGISTRAR W. J. H. S. S. E.			
24b. REGISTRAR'S SIGNATURE Arthur S. Hines				DATE AUG 28 '58			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9322 CERTIFICATE OF DEATH

09317

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN lb <u>15 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germantown</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital</u>				d. STREET ADDRESS <u>c/o Henry King</u>			
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>Bernard</u> Last <u>Stewart</u>				4. DATE OF DEATH Month <u>August</u> Day <u>21</u> Year <u>19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/4/77</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Stewart</u>				14. MOTHER'S MAIDEN NAME <u>Mary Louise Gordon</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT <u>Hospital Records</u>		Address <u>Olney, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute Pyelonephritis</u> DUE TO (c) <u>Prostatic Hypertrophy with Obstructing Uropathy</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 weeks</u> <u>Unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/6</u> , 19 <u>58</u> , to <u>8/21</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8/20</u> , 19 <u>58</u> , and that death occurred at <u>1:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>8/22/58</u>							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		PHYSICIAN'S NAME (Type) <u>C. H. Ligon, M.D.</u> <u>Sandy Spring, Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>8/23/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Rose</u>		22d. LOCATION (City, town, or county) (State) <u>Cloppers, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Sworden</u> ADDRESS <u>Rockville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 25 '58</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9323

CERTIFICATE OF DEATH

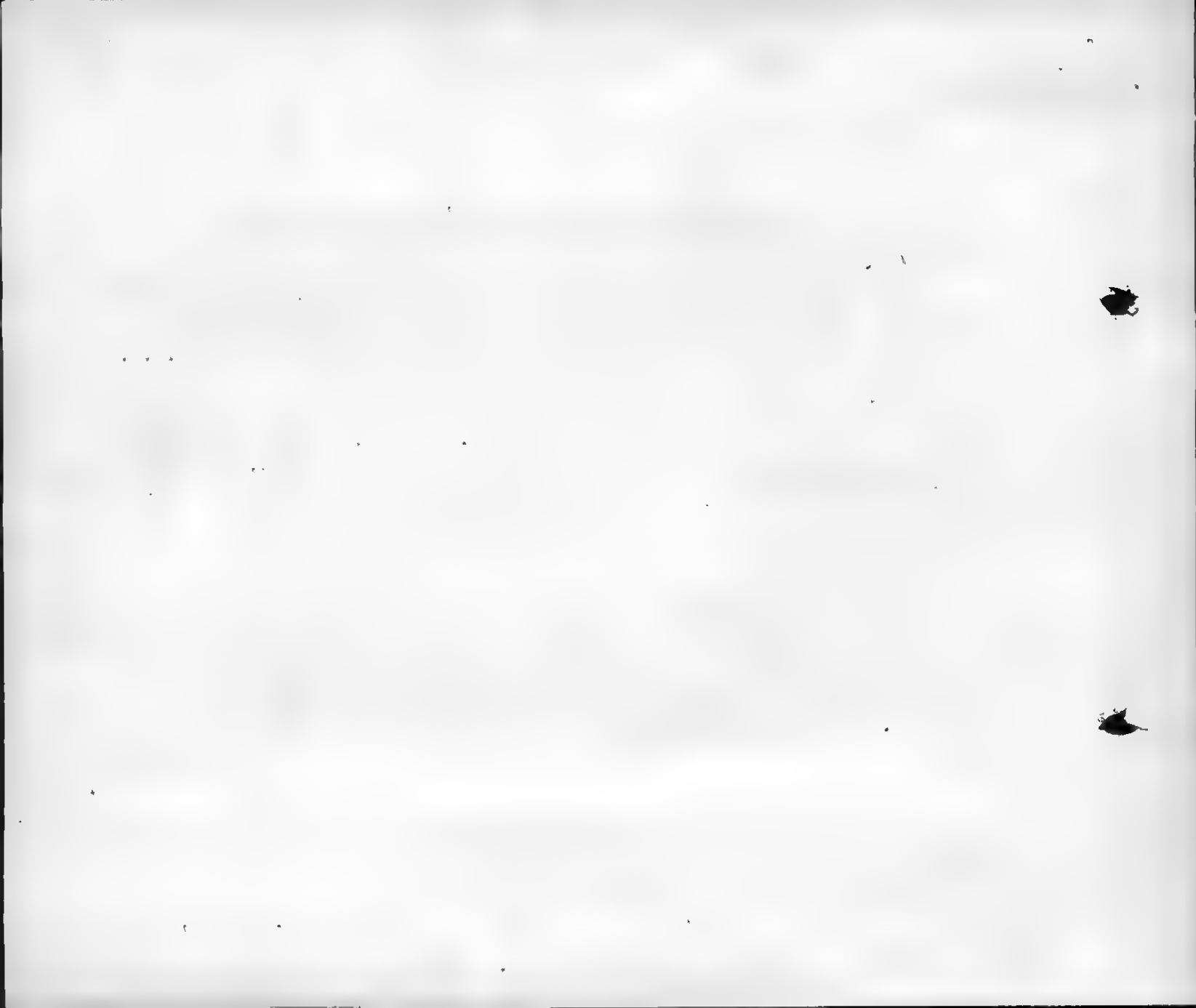
09318

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAYHILL, SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAYHILL, SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 15,310 Layhill Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) VIOLA L STEWART		4. DATE OF DEATH Month AUGUST Day 9 Year 19 58	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/6/96
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES H. JENKINS		14. MOTHER'S MAIDEN NAME ARABELLE LaFEVER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mr. John R. Stewart, 15,310 Layhill Road		Address Layhill, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatic Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 30 min 20 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 1938 to Aug 2 1958 , that I last saw the deceased alive on Aug 2 1958 , and that death occurred at 7:00 PM , from the causes and on the date stated above			
ACTUAL SIGNATURE W. B. WARDROP M.D.		ADDRESS (Street, city or town, state) 837 Bonifant St. Silver Spring, Md.	
PHYSICIAN'S NAME (Type) W. B. WARDROP		DATE SIGNED 8/12/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/12/58	
22c. NAME OF CEMETERY OR CREMATORY ST. LINCOLN CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR AUG 12 1958		24b. REGISTRAR'S SIGNATURE Arthur L. Krantz	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached from the certificate as the burial-transit permit. Then please remove carbon paper and the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9324

CERTIFICATE OF DEATH

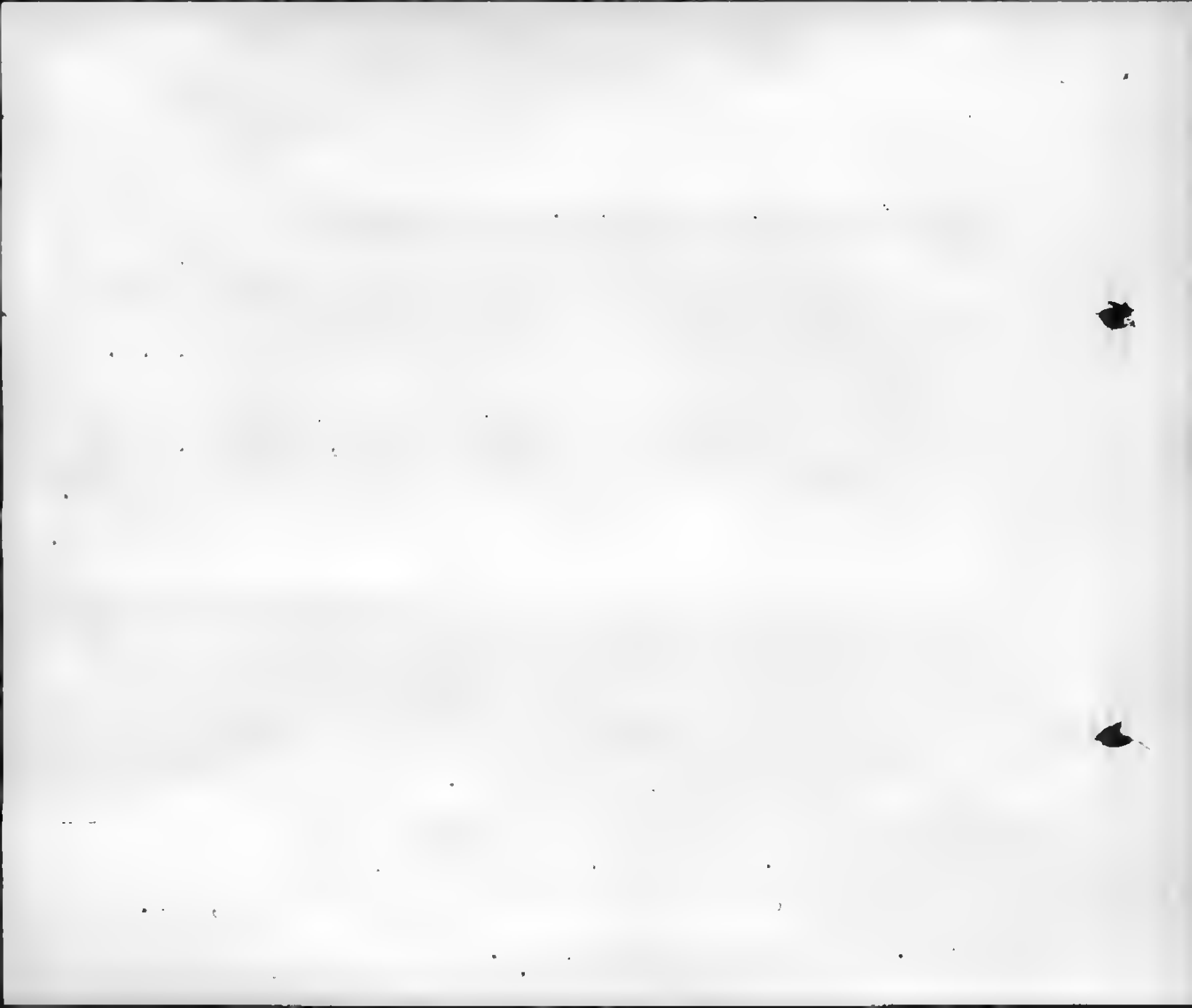
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 138 days		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Michigan		b. COUNTY Iron Mountain		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS 602 East C Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Lois Wilhelmina Straub		4. DATE OF DEATH Month Day Year August 2, 19 58		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 15, 1902		9. AGE (In years last birthday) 55 yrs		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS Months Days Hours Min					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Minnesota		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME James Palin		14. MOTHER'S MAIDEN NAME Frankie Phinney		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic adrenal carcinoma DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 min.		11 mos.		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 58		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 17, 19 58 to August 2, 19 58 , that I last saw the deceased alive on August 2, 19 58 , and that death occurred at 12:55 PM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) The Clinical Center		DATE SIGNED 8-2-58		ACTUAL SIGNATURE Theodore L. Goodfriend M.D.		PHYSICIAN'S NAME (Type) Theodore L. Goodfriend, M. D.		22a. BURIAL, CREMATION, or other disposition Burial		22b. DATE THEREOF 8/6/58		22c. NAME OF CEMETERY OR CREMATORY Cemetery Park		22d. LOCATION (City, town, or county) (State) Iron Mountain, Mich.					
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS 7557 Wisconsin Ave. Bethesda, Md.		24a. REC'D BY REGISTRAR Aug 5 '58		24b. REGISTRAR'S SIGNATURE W. H. Leach															

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9325

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>			
c. LENGTH OF STAY in 1b <u>4 weeks</u>				d. STREET ADDRESS <u>204 Poplar Ave</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brokegrove Foundation</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Stuvilla Jane Stuart</u>				4. DATE OF DEATH Month Day Year <u>Aug. 19 1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 4 - 1870</u>	9. AGE (In years last birthday) <u>88</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Benson Cornell</u>				14. MOTHER'S MAIDEN NAME <u>Susan Owens</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Diabetes mellitus</u>							<u>2-3 yrs?</u>
DUE TO <u>660X</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u>							<u>4 yrs 22</u>
DUE TO (c) <u>(moribund condition)</u>							<u>24 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>7-25</u> , 19 <u>58</u> , to <u>8-18</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8-8</u> , 19 <u>58</u> , and that death occurred at <u>3:42</u> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John R. Spencer</u> M.D.				ADDRESS (Street, city or town, state) <u>Columbia Road, Westminster, Md.</u>			
DATE SIGNED <u>Aug 18 1958</u>							
PHYSICIAN'S NAME (Type) <u>JOHN R. SPENCER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/21/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Halley's Funeral Home</u> ADDRESS <u>mt. Rainier Md.</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 22 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon page 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9326

CERTIFICATE OF DEATH

09321

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN TB 5 mins.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington D.C.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban				d. STREET ADDRESS 3905 Jocelyn Street, N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Thomas Middle R. Last Taylor				4. DATE OF DEATH Month August Day 19 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/22/90	9. AGE (In years last birthday) yrs. 68	IF UNDER 1 YEAR Months 68	IF UNDER 24 HRS. Days 68 Hours 68 Min 68	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Economist (Retired)		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Jackson Taylor				14. MOTHER'S MAIDEN NAME Martha Nuttall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO 579-05-9950		17. INFORMANT Mary O Taylor Address 3905 Jocelyn St., N.W. Wash. DC			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction, severe DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Coronary sclerosis, severe (c) Arteriosclerosis & hypertension						INTERVAL BETWEEN ONSET AND DEATH 1 hour 10 months 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1951 to Aug 19, 1958 , that I last saw the deceased alive on Aug 19, 1958 , and that death occurred at 9:15 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Stewart Clapp		M.D. 3921 Ingomar St		DATE SIGNED 8-19-58			
PHYSICIAN'S NAME (Type) Stewart Clapp		Wash DC					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/22/1958		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem. - Arlington, Virginia		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE A. H. Hines Co. 2901-14 st NW				24a. REC'D BY REGISTRAR DATE AUG 21 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

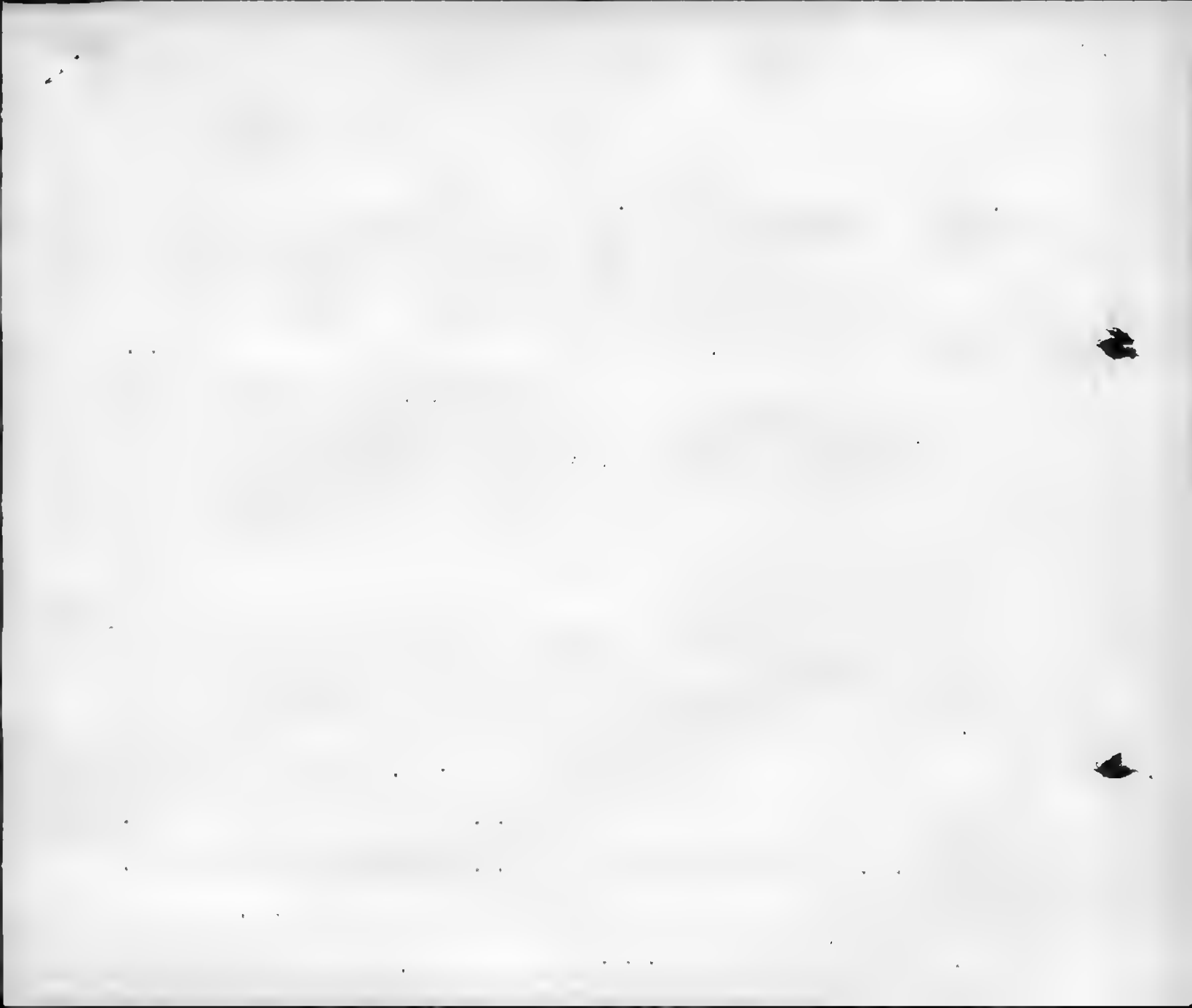
9327

CERTIFICATE OF DEATH

Reg. Dist. No. 215

09322

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE South Carolina SOUTH CAROLINA COUNTY			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 2 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First "A" Middle "J" Last THOMAS				4. DATE OF DEATH Month August Day 4 Year 19 58			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10 August 1926	
9. AGE (In years last birthday) yrs 31		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner				10b. KIND OF BUSINESS OR INDUSTRY U.S. Marine Corps		11. BIRTHPLACE (State or foreign country) Texas	
12 CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Calvin THOMAS				14. MOTHER'S MAIDEN NAME Erie RRAVEN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes, Currently				16. SOCIAL SECURITY NO. Unknown		17 INFORMANT Official Navy Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) MULTIPLE PULMONARY THROMBOSES DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) SICKLE CELL CRISIS DUE TO (c) SICKLE CELL ANEMIA				INTERVAL BETWEEN ONSET AND DEATH 36 hours 36 hours Unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 2 August , 19 58 , to 4 August , 19 58 , that I last saw the deceased alive on 4 August , 19 58 , and that death occurred at 5:43A. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE F. S. Caldwell				ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 8-5-58			
PHYSICIAN'S NAME (Type) F. S. CALDWELL, LT, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-9-58		22c. NAME OF CEMETERY OR CREMATORY Beaufort Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Beaufort, S. C.	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers, 1400 Chapin St. N.W. Wash. D. C.				24a. REC'D BY REGISTRAR AUG 6 '58		24b. REGISTRAR'S SIGNATURE Alfred...	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

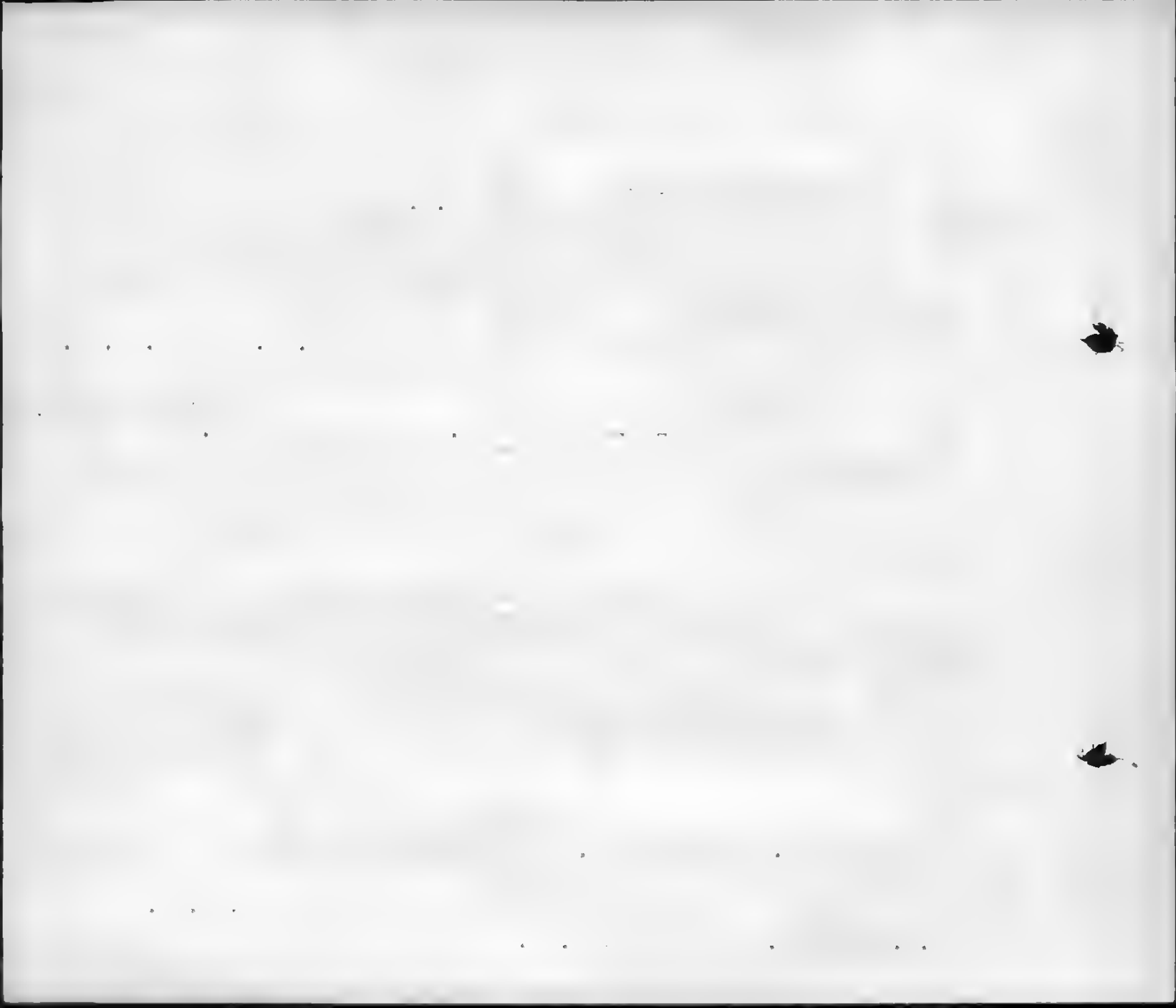
9328

CERTIFICATE OF DEATH

00323

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Miami Shores			
d. NAME OF HOSPITAL, CLINIC, OR INSTITUTION (If not in hospital, give street address) Resmor Sanitarium & Hospital				e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Milton Charles Thompson				4. DATE OF DEATH Month Day Year August 8 1958			
5 SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/16/1887	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Druggist		10b. KIND OF BUSINESS OR INDUSTRY Medicine		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Marion Clay Thompson				14. MOTHER'S MAIDEN NAME Elizabeth Caufield			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO 578-01-2503		17. INFORMANT Address Miami Shores, Fla Eva E. Thompson-9325 N.W. 2nd Court			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MURDER BY SHOTGUN DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) WOUND TO CHEST DUE TO (c) SHOTGUN WOUND							INTERVAL BETWEEN ONSET AND DEATH 3 HOURS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Accident while driving car							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a. m. p. m. 19	Month. 8	Day. 11	Year 1958	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 4890 Battery Lane	20f. (City or town) Bethesda	(County) Montgomery
21. I certify that I attended the deceased from 7/25/58 19 58 to 8/11/58 19 58 that I last saw the deceased alive on 8/11/58 19 58 , and that death occurred at 2:15 p. m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Bethesda Montgomery Maryland DATE SIGNED 8/11/58							
ACTUAL SIGNATURE Charles J. Savarese, Jr. M.D.				DATE SIGNED 8/11/58			
PHYSICIAN'S NAME (Type) Charles J. Savarese, Jr.				ADDRESS Bethesda Montgomery Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/11/58		22c. NAME OF CEMETERY OR CREMATORY Congressional Cemetery Washington, D. C.		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. Washington, D. C.				24a. REC'D BY REGISTRAR DATE AUG 11 '58		24b. REGISTRAR'S SIGNATURE Alfred Smith	



9329

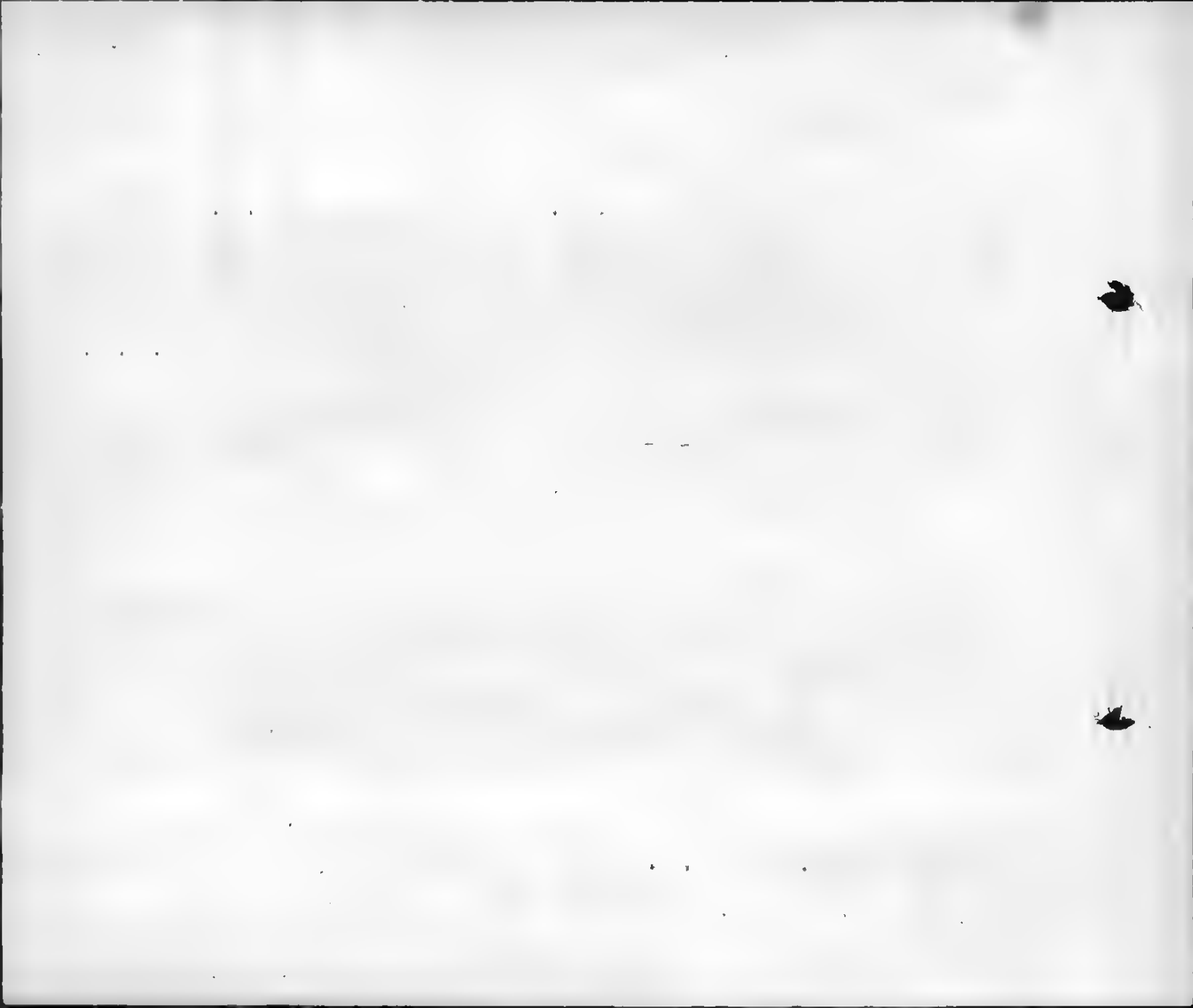
CERTIFICATE OF DEATH

09324

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Virginia b. COUNTY Fairfax	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 38 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. STREET ADDRESS 308 Tapawingo Road, S. E.	
3. NAME OF DECEASED (Type or print) First Leafy Middle Brandon Last Tibbs		4. DATE OF DEATH Month August Day 20 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 28, 1893
9. AGE (In years last birthday) yrs 65		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME William Stone	
14. MOTHER'S MAIDEN NAME Cora Seay		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO 223-20-8097		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FECAL PERITONITIS 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) NUMEROUS ENTERO-ENTERIC & ENTERO-UTERINE FISTULAS DUE TO (c) CARCINOMA OF CERVIX - STATUS 4 YRS POST PELVIC EXENTERATION INTERVAL BETWEEN ONSET AND DEATH 1 WEEK 3 WEEKS 4 YRS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BILATERAL HYDRONEPHROSIS & CHRONIC PYELONEPHRITIS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 13, 1958 to August 20, 1958 , that I last saw the deceased alive on August 20, 1958 , and that death occurred at 4:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Jack H. Bloch, M.D. M.D.		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) Jack H. Bloch, M. D.		DATE SIGNED 8/21/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-23-58	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill	22d. LOCATION (City, town, or county) (State) Freightland Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Don Eickens		24a. REC'D BY REGISTRAR DATE AUG 25 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Funn

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 11 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9330

CERTIFICATE OF DEATH

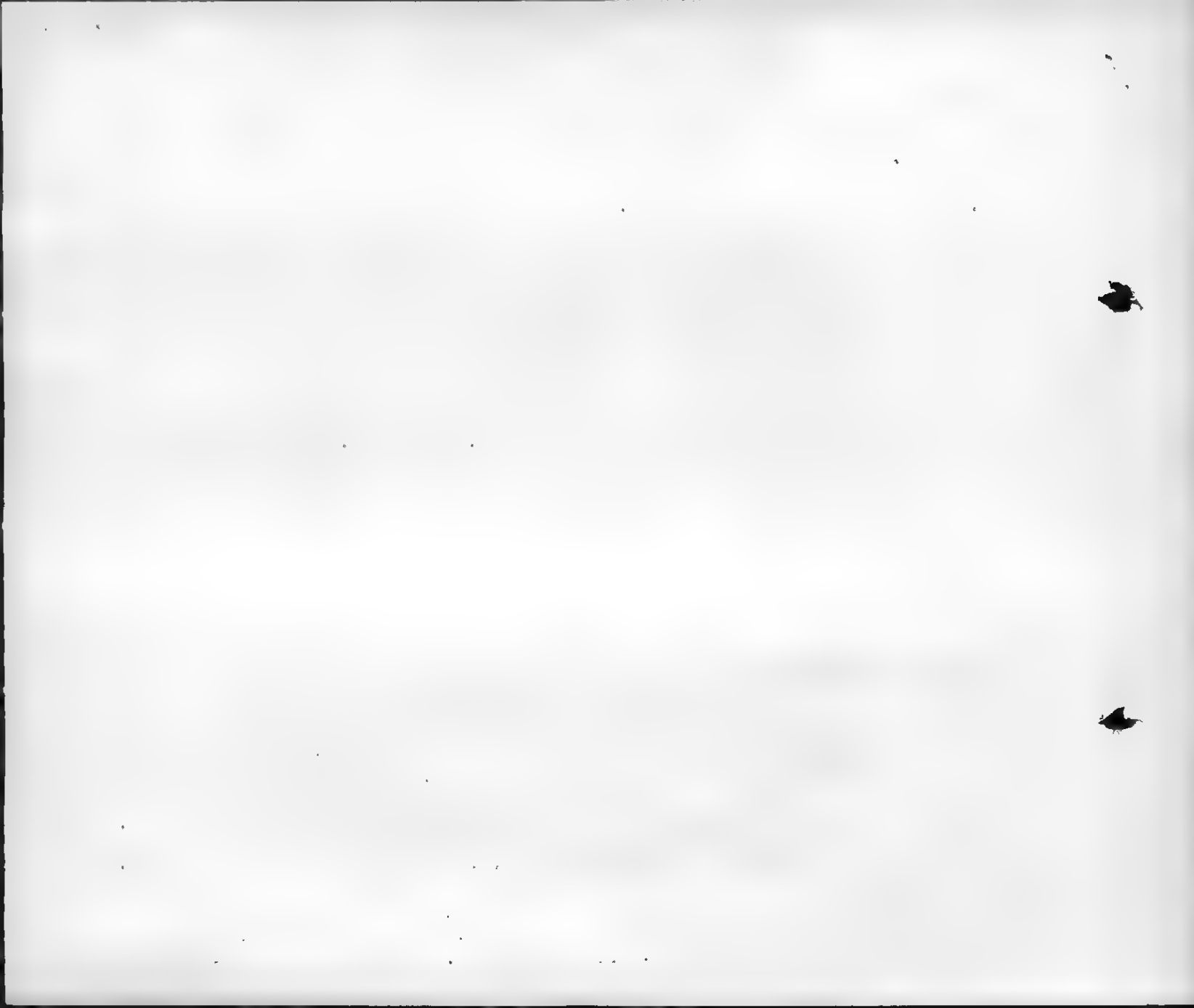
09325

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY M	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 125 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle Gibson Last TOBIN		4. DATE OF DEATH Month August Day 11 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 17 August 1894
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner, Rear Admiral, U.S. Navy, Retired		10b. KIND OF BUSINESS OR INDUSTRY West Virginia	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Robert E. TOBIN		14. MOTHER'S MAIDEN NAME Nellie FARRELL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) WW-I & II	
17. INFORMANT Wife, Mrs. Carolyn O. TOBIN (Same As #2)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chlorblastoma multiforme bilateral. DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH in excess of 1 year.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8 April 1958 , to 11 August 1958 , that I last saw the deceased alive on 11 August 1958 , and that death occurred at 11:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. H. Druckemiller		DATE SIGNED 8-12-58	
PHYSICIAN'S NAME (Type) W. H. DRUCKEMILLER, CAPT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-15-58	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey		ADDRESS 7557 Wisconsin Ave., Bethesda, Md.	
24a. REC'D BY REGISTRAR AUG 14 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Knecht	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

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9331

Item 1 of 1, 0252 8/7/58

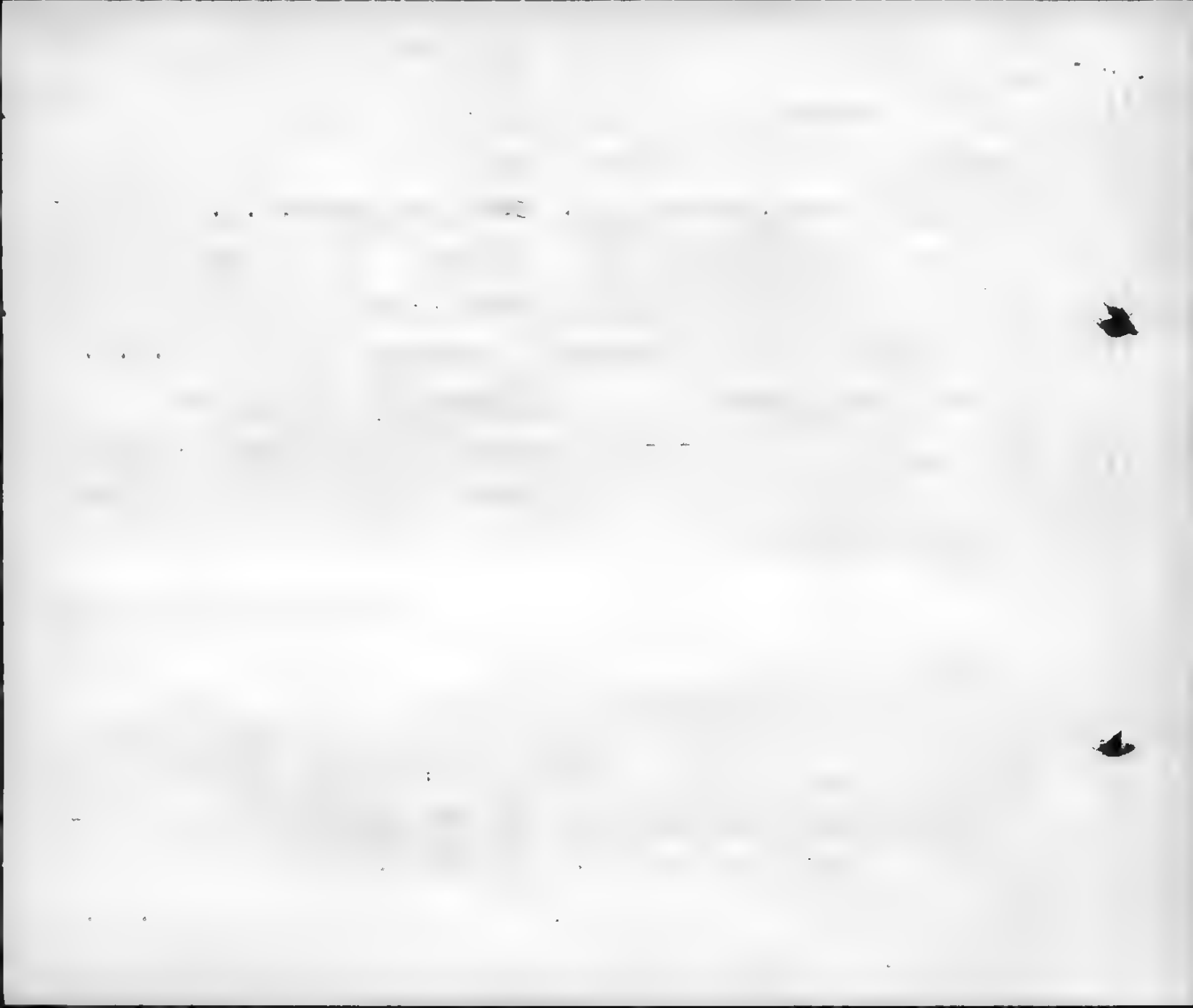
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09326

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 42 1/2 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 42 X 3 d. STREET ADDRESS 3820 Southern Avenue, S. E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Malcolm Claire Weyant Tomlinson		4. DATE OF DEATH Month Day Year August 4 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 16, 1884
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 6 18	11. IF UNDER 24 HRS. Hours Min. 6 18
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Genealogist		10b. KIND OF BUSINESS OR INDUSTRY Self-employed	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph Deacon Tomlinson		14. MOTHER'S MAIDEN NAME Katharine Virginia Dare Weyant	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 578-34-6130	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myelogenous Leukemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 4 mos.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 23, 19 58 to August 4, 19 58 , that I last saw the deceased alive on August 4, 19 58 , and that death occurred at 12:45 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Arthur T. Teplitzky		ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) Arthur T. Teplitzky, M. D.		DATE SIGNED 8-4-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 8/5/58	
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory		22d. LOCATION (City, town, or county) (State) Prince George Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR AUG 6 '58		24b. REGISTRAR'S SIGNATURE W. H. ...	



9332

CERTIFICATE OF DEATH

Reg. Dist. No.

09327

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 21 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS 4600 High Street			
3. NAME OF DECEASED (Type or print) First Lacey Middle Balch Last Tschiffely				4. DATE OF DEATH Month August Day 30 Year 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 13, 1874	9. AGE (In years last birthday) yrs. 83	IF UNDER 1 YEAR Months 10 Days 5 Hours 30 Min	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Government		10b. KIND OF BUSINESS OR INDUSTRY Treasury Dept.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George R. Rice				14. MOTHER'S MAIDEN NAME Elberta Moore			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Daughter Mrs. Dorothy T. Moore		Address As above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FV & from Neck Tumor & legs 40 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Embolus from tumor DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 10⁵⁵ - 10³⁰ AM	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Fall at Home			
20c. TIME OF INJURY Hour 4 p. m. Month 8 Day 9 Year 19 58				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
20f. (City or town) Chevy Chase				20g. (County) Montgomery		20h. (State) Md.	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on 29 Aug. 19 JK , and that death occurred at 11:50 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Milton C. Coburn				ADDRESS (Street, city or town, state) 1726 E. 1st St. Wash D.C.			
DATE SIGNED SEP 3 '58				M.D. 1726 E. 1st St. Wash D.C.			
PHYSICIAN'S NAME (Type) Milton C. Coburn							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
CREMATION		SEPT 3, 1958		LEES CREMATORY		300 H E ST NE WASH D C	
23. FUNERAL DIRECTOR'S SIGNATURE J. W. Lees Sons - Wash. D. C.				24a. REC'D BY REGISTRAR SEP 3 '58		24b. REGISTRAR'S SIGNATURE Arthur E. Hance	

TO HOSPITAL OR ATTENDING PHYSICIAN: The form requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9333

CERTIFICATE OF DEATH

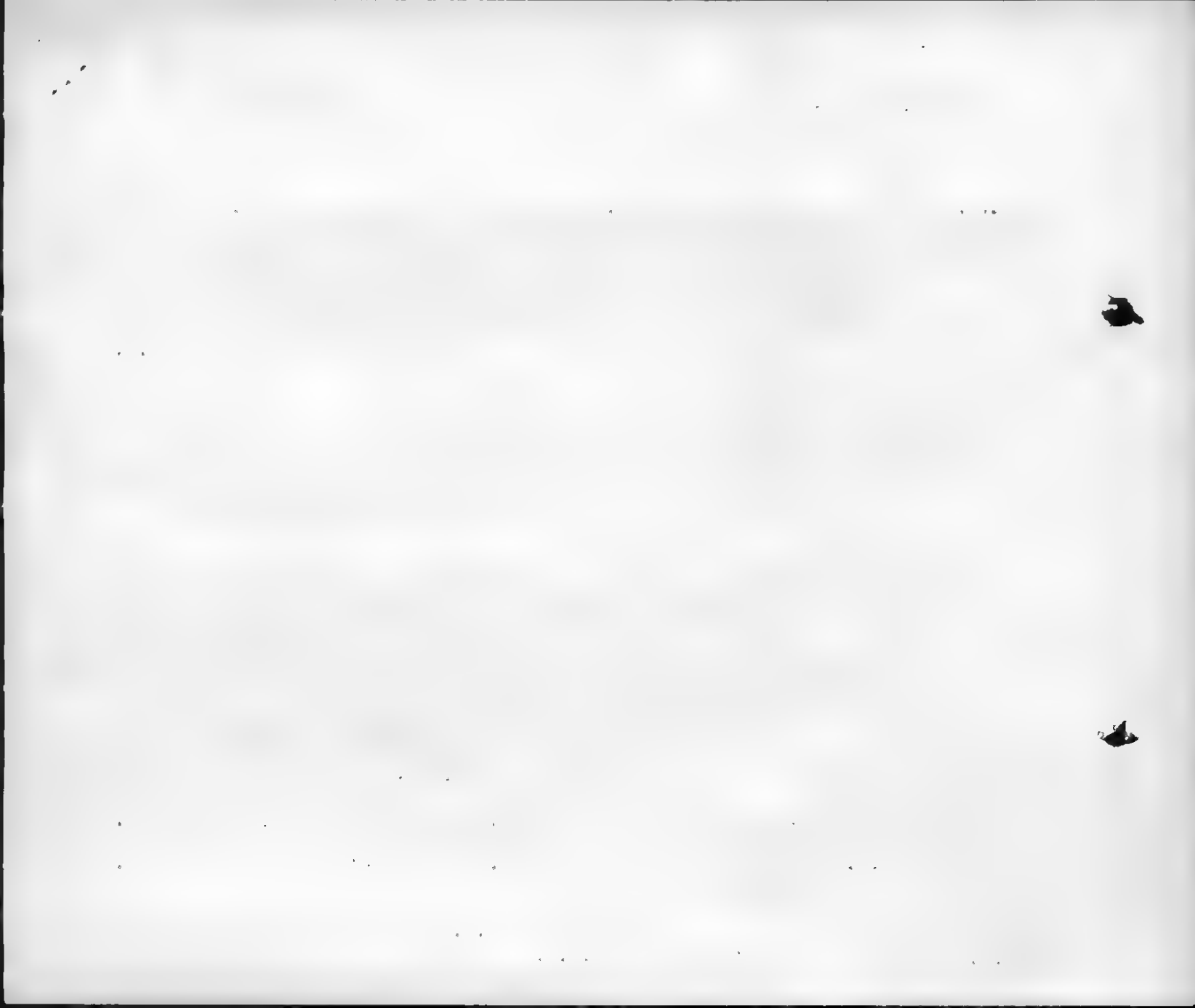
Reg. Dist. No.

99328

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 110 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
f. STREET ADDRESS 1737 "P" Street, N.W.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Samuel Middle (nmn) Last VANCE		4. DATE OF DEATH Month August Day 12 Year 1958	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 15 March 1916
9. AGE (In years last birthday) 42 yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Commercial	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.	
13 FATHER'S NAME Frank VANCE		14 MOTHER'S MAIDEN NAME Lillian YOUNG	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes 9-3-42 to 1-10-46		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Official Navy Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Squamous cell Carcinoma, with DUE TO Metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastases (c) Metastases			INTERVAL BETWEEN ONSET AND DEATH 5 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 23 April , 19 58 , to 12 August , 19 58 , that I last saw the deceased alive on 11 August , 19 58 , and that death occurred at 2:30 A. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE W.D. Hooper		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 8-12-58	
PHYSICIAN'S NAME (Type) W.D. HOOPER, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-14-58	22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE W.E. Jarvis		ADDRESS Washington, D.C.	
24a. REC'D BY REGISTRAR AUG 14 58		24b. REGISTRAR'S SIGNATURE Arthur S. Hays	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

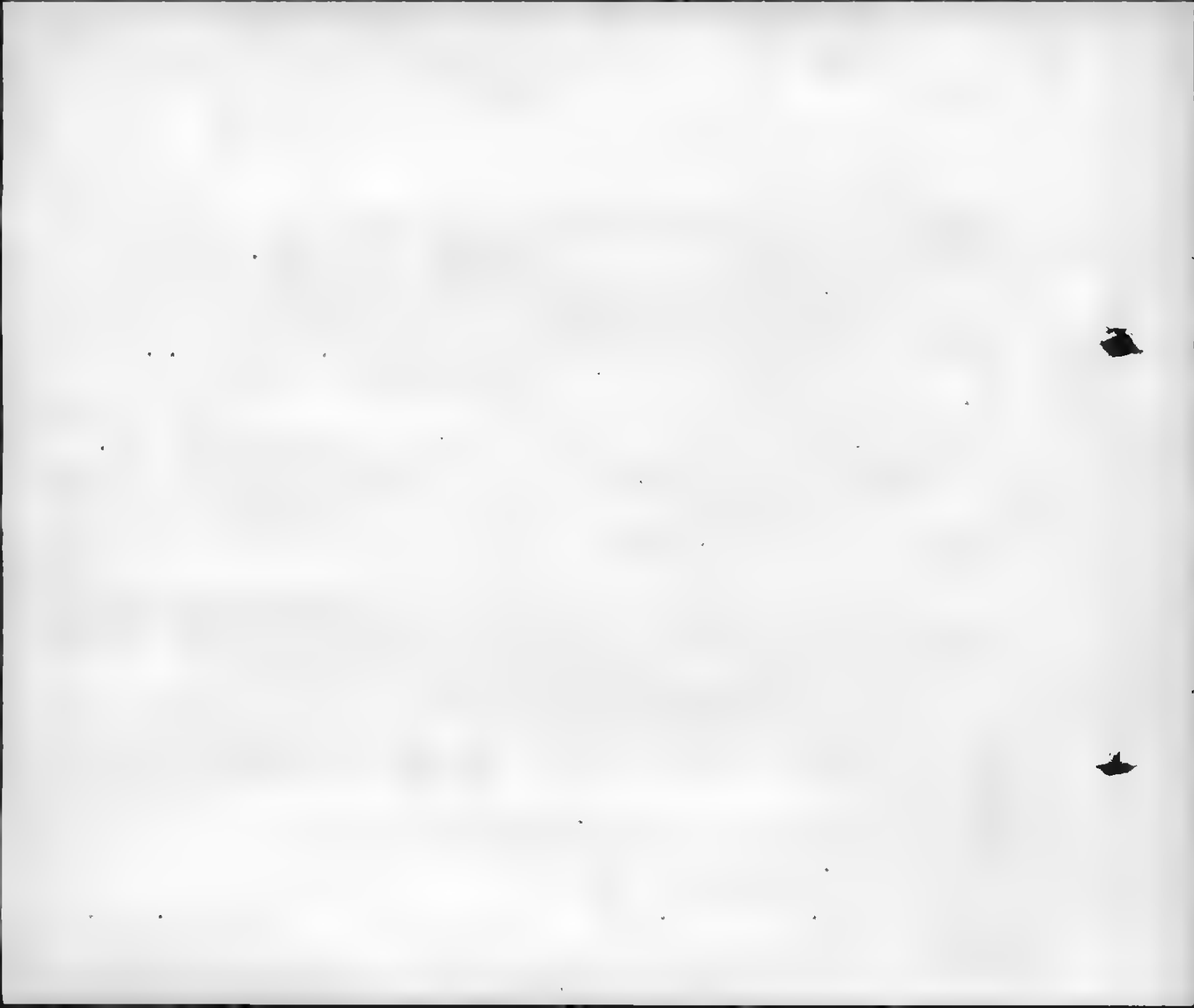
09329

9334

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fairland</u> c. LENGTH OF STAY IN lb <u>9 months</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Fairland Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived If institution—Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Ch. Co.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harman</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>S</u> Last <u>Vawter</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>22</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 25, 1873</u>
9. AGE (In years last birthday) <u>85</u> yrs		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> M'n <u></u>	IF UNDER 24 HRS Months <u></u> Days <u></u> Hours <u></u> M'n <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Green Spring, Va.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>J. William Pike</u>	
14. MOTHER'S MAIDEN NAME <u>Margaret Denny</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO <u>none</u>		17. INFORMANT Address <u>Mrs. Virginia Groseclose, Colesville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>444x Arteriosclerotic Heart Disease</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>Senil Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u> <u>20 yrs</u> <u>20 yrs</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5/19</u> , 19 <u>58</u> , to <u>8/22</u> , 19 <u>58</u> that I last saw the deceased alive on <u>8/22</u> , 19 <u>58</u> , and that death occurred at <u>10:00</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. M. Warren</u>		ADDRESS (Street, city or town, state) <u>Laurel Md</u>	
PHYSICIAN'S NAME (Type) <u>John W. Warren</u>		DATE SIGNED <u>8/22/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug 25, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Highland, Howard CO., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert D. [illegible]</u>		24. REC'D BY REGISTRAR <u>August 24 58</u>	
ADDRESS <u>Laurel Md</u>		24b. REGISTRAR'S SIGNATURE <u>Robert D. [illegible]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9335

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md.</u>			
c. LENGTH OF STAY IN 1b <u>3 1/2</u> years				d. STREET ADDRESS <u>10915 Jarboe Ave.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Green's Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>George Eugene Vermont</u>				4. DATE OF DEATH Month Day Year <u>August 21 1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 15, 1876</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chef (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>New Hampshire</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Fred Vermont</u>				14. MOTHER'S MAIDEN NAME <u>Unknown CLAIRS MICHAUD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>26409 4685</u>		17. INFORMANT <u>Mrs. John W. Wrathall</u>		Address <u>10915 Jarboe Ave. SS.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>NOV. 16, 1957</u> to <u>AUG 21, 1958</u> , that I last saw the deceased alive on <u>AUGUST 21, 1958</u> , and that death occurred at <u>3:30</u> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>James A. Roberts</u> M.D. <u>8907 GEORGIA AVE. AUSTIN, TX 78701</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>James A. Roberts</u> <u>SILVER SPRING, MARYLAND</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-28-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>F. Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James A. Roberts</u>				ADDRESS <u>Silver Spring, Md.</u>		24a. REC'D BY REGISTRAR <u>AUG 25 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper.



9336

CERTIFICATE OF DEATH

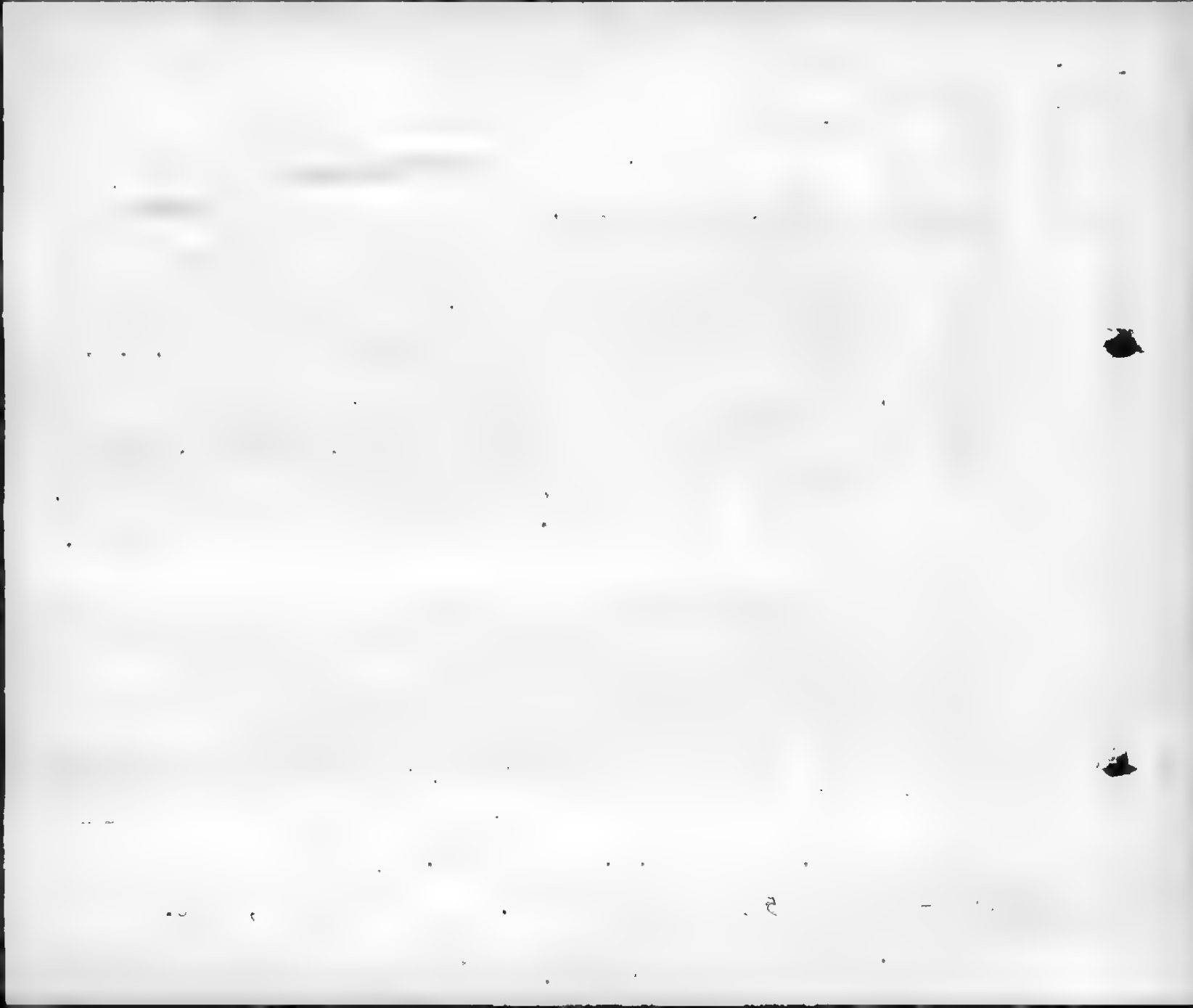
Reg. Dist. No.

09331

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Wisconsin b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 17 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Milwaukee			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 4209 North 42nd Place			
3. NAME OF DECEASED (Type or print) First Robin Middle John Last Vilar		4. DATE OF DEATH Month August Day 2 Year 1958					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 1, 1954	9. AGE (In years last birthday) yrs 4	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Robert L. Vilar				14. MOTHER'S MAIDEN NAME Nancy Samuelson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Wilm's tumor with widespread metastases DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 48 hrs. 1 yr.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 16, 1958 to August 2, 1958 , that I last saw the deceased alive on August 2, 1958 , and that death occurred at 2:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Harold R. Silberman M.D. The Clinical Center 8-2-58 National Institutes of Health Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		8/6/58		Milwaukee Cem.		Wilwaukee, Wisc.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS 7557 Wisconsin Ave.		24a. REC'D BY REGISTRAR DATE AUG 5 '58	
				Bethesda, Md.		24b. REGISTRAR'S SIGNATURE <i>Alfred</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9337

CERTIFICATE OF DEATH

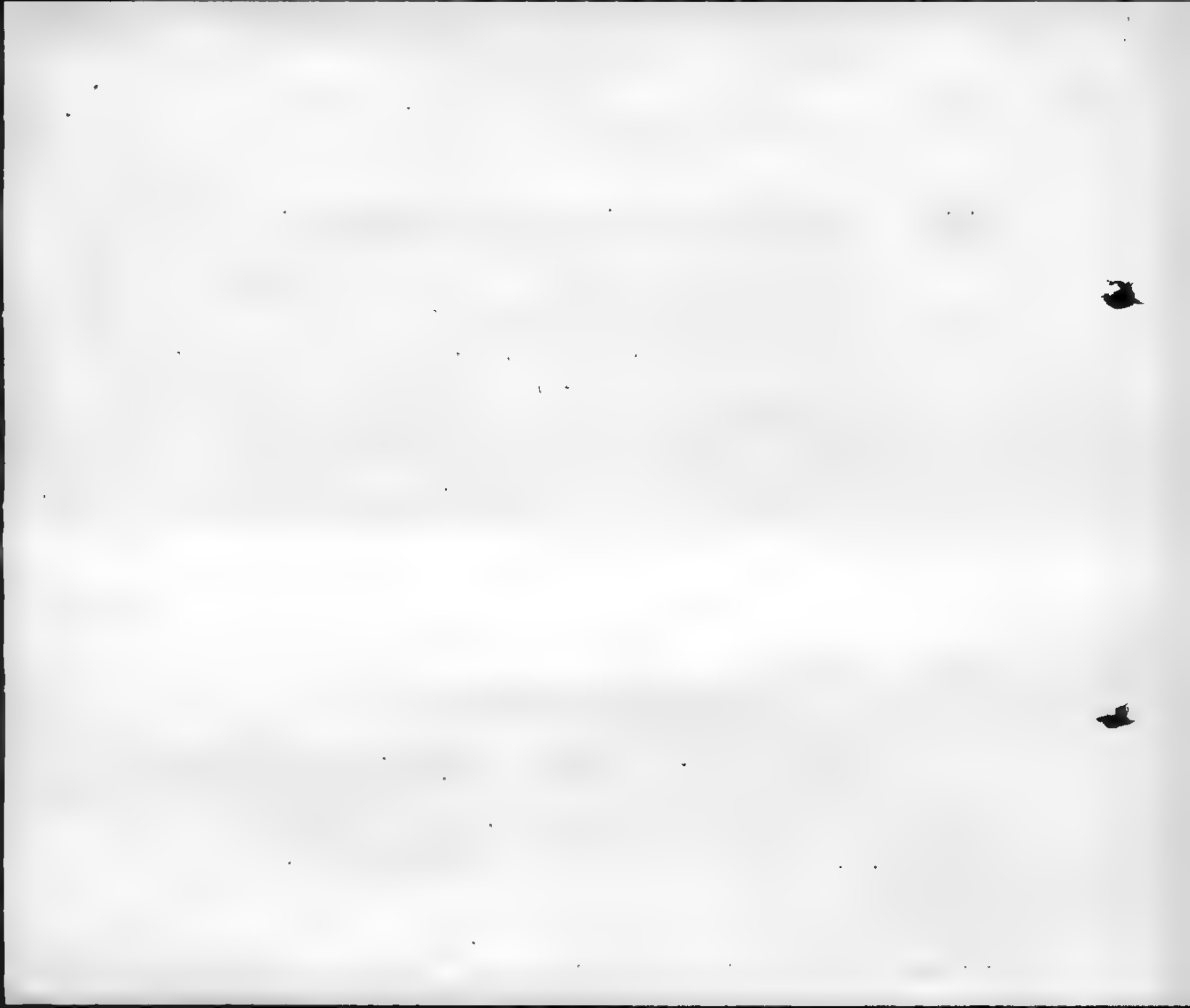
Reg. Dist. No. 215

1. PLACE OF DEATH COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) STATE District of Columbia COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 80 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> Washington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 826 21st Street, N.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Thomas Fulton VINES				4. DATE OF DEATH Month Day Year August 2 1958			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 27, 1916		9. AGE (In years last birthday) 42 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Skycap		10b. KIND OF BUSINESS OR INDUSTRY Airport Services		11. BIRTHPLACE (State or foreign country) No. Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Douglas VINES				14. MOTHER'S MAIDEN NAME Ada BUCHANAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 577-26-2523		17. INFORMANT Address (W) Mrs. Myrtle Vines, same as #2 above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease, malignant DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH over 2 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 14 , 19 58 , to August 2 , 19 58 , that I last saw the deceased alive on August 2 , 19 58 , and that death occurred at 5:18 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE C. U. Shilling M.D. ADDRESS (Street, city or town, state) U. S. Naval Hospital, NMMC DATE SIGNED 8-2-58 PHYSICIAN'S NAME (Type) C. U. SHILLING LT MC USN Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-6-58		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W. E. JARVIS				ADDRESS Washington, D.C.		24a. REC'D BY REGISTRAR AUG 6 '58	
24b. REGISTRAR'S SIGNATURE W. E. Jarvis				24c. REGISTRAR'S SIGNATURE W. E. Jarvis			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. The law requires that the death certificate be executed within 72 hours after death.

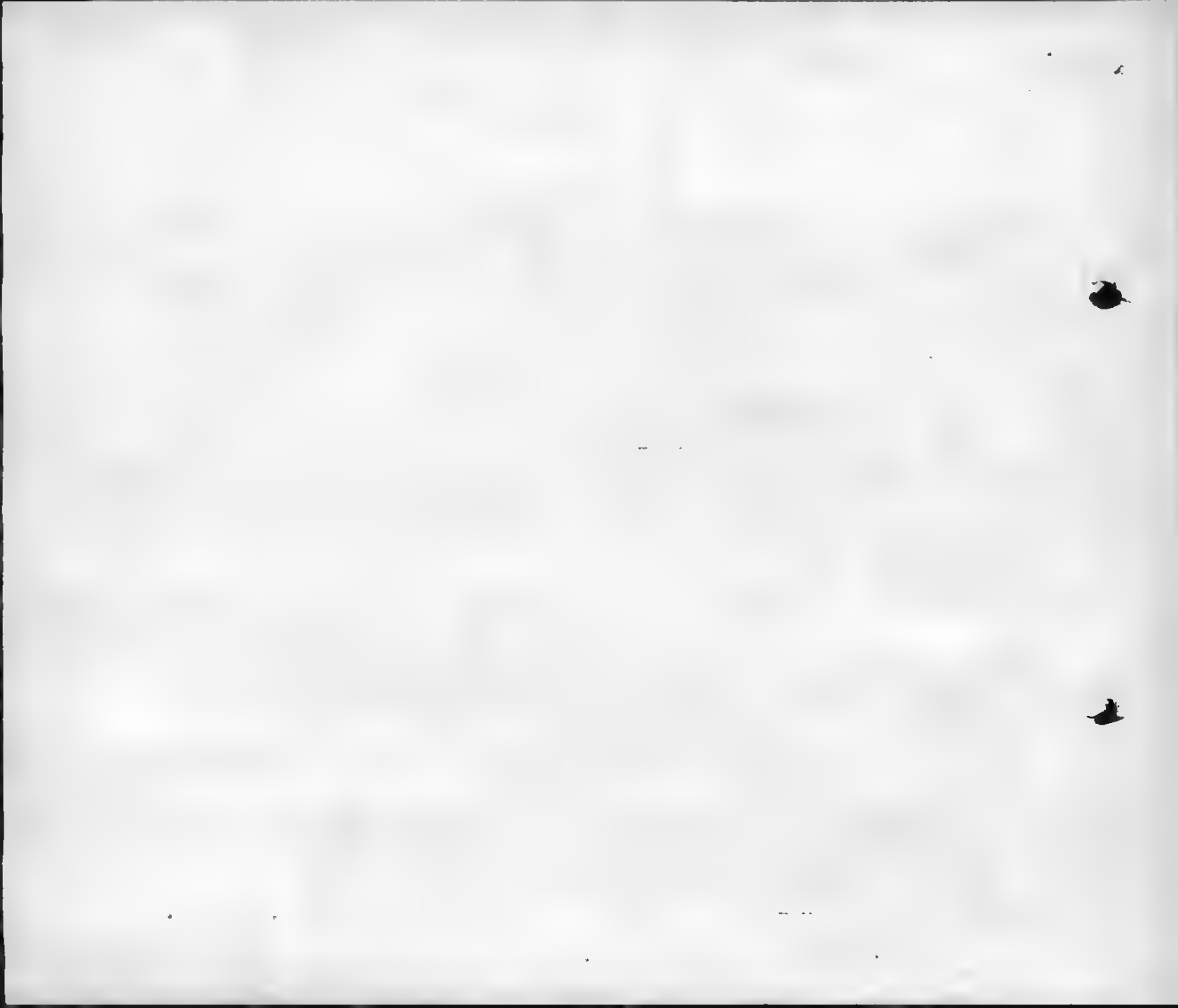
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



VS AISME
BM 2/57

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Pa</u> b. COUNTY <u>Lancaster</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>		c. LENGTH OF STAY IN 1b <u>1 wk</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3707 Cherry Chase Lake Dr</u>		e. STREET ADDRESS <u>1619 Monsey Ave</u>	
3. NAME OF DECEASED (Type or print) <u>George Barron</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>31</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-15-1878</u>
9. AGE (in years last birthday) <u>80</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Businessman</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Vi Pond</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Fulton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>071-09-7940</u>	
17. INFORMANT <u>Wendy Nephew - Nurse at Home</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>8</u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		DATE SIGNED <u>8-31-58</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit</u>	22b. DATE THEREOF <u>9-2-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Forest Hills Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Scranton, Penna.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 2 '58</u>	
ADDRESS <u>Bethesda, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	



9339

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09334

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>14 mo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens Nursing Home</u>				d. STREET ADDRESS <u>616 Pershing Dr</u>			
3. NAME OF DECEASED (Type or print) <u>Emma Platz Wadley</u>				4. DATE OF DEATH <u>Aug 4 1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-15-1862</u>	
9. AGE (In years, last birthday) <u>96</u> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Wash. D.C.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Platz</u>				14. MOTHER'S MAIDEN NAME <u>Maria Ossinger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO <u>Nursing home record</u>		17. INFORMANT <u>Rechel</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Circulatory failure</u> <u>903.7</u> DUE TO (b) <u>Fracture of left hip</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>1 mo - 8 days</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arterio sclerosis heart disease</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <u>Fell on bed room floor</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u>6/26 1958</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, off campus, etc.) <u>Nursing home</u>		20f. (City or town) <u>Kensington</u> (County) <u>Montg</u> (State) <u>md</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Brosch</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>8/7/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>		22d. LOCATION (City, town, or county) <u>Washington, D.C.</u> (State) <u>md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>				24a. REC'D BY REGISTRAR <u>Albrecht</u>		24b. REGISTRAR'S SIGNATURE <u>Albrecht</u>	
2901 14th St. N.W. Washington 9, D.C.				DATE AUG 6 '58			



9340

CERTIFICATE OF DEATH

Reg. Dist. No.

09335

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Alta Vista Rest Home</u>		d. STREET ADDRESS <u>5211 Roosevelt St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Chaster</u> Middle <u>Harner</u> Last <u>Harner</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>16</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 30, 1917</u>
9. AGE (In years last birthday) <u>40</u> yr.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Patent Attorney</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mich.</u>	
11. BIRTHPLACE (State or foreign country) <u>Mich.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Elijah Harner</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Nelson Harner</u>	
17. INFORMANT <u>Nelson Harner</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO <u>Atherosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>2 years</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute acquired hemolytic anemia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 22, 1958</u> , to <u>August 16, 1958</u> , that I last saw the deceased alive on <u>August 12, 1958</u> , and that death occurred at <u>5:09 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. Roger Hunt</u> M.D.		DATE SIGNED <u>Aug 16, 1958</u>	
PHYSICIAN'S NAME (Type) <u>C. Roger Hunt, M.D.</u>		<u>Washington, D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>AUG. 19, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>	22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>I. P. Ives, M.D.</u>		ADDRESS <u>2947 Wilson Blvd. ARLINGTON, VA.</u>	
24a. REC'D BY REGISTRAR <u>AUG 19 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached from the certificate and retained by the funeral director.

9341

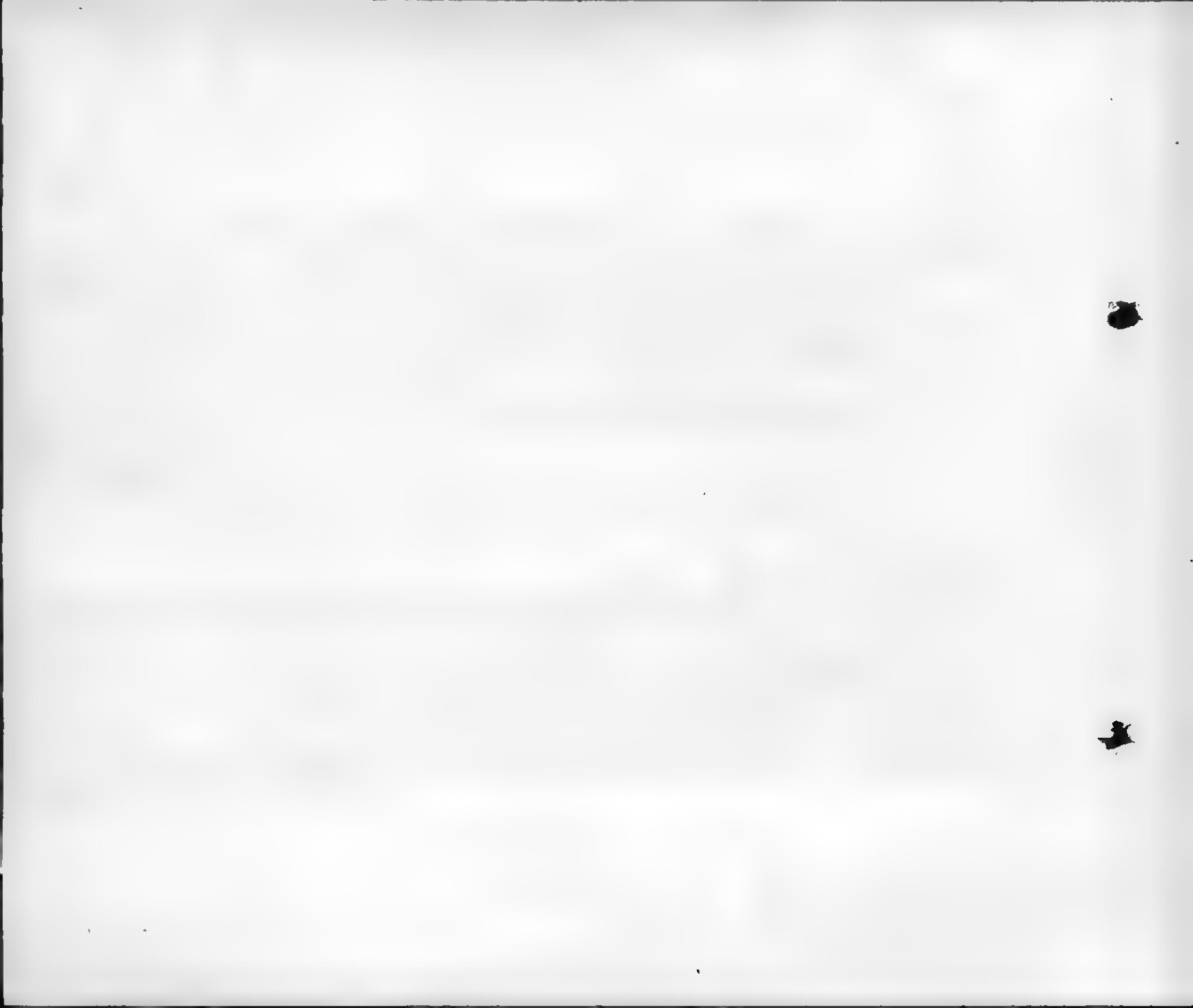
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09336

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GAITHERSBURG</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GAITHERSBURG</u>	
c. LENGTH OF STAY IN 1b <u>3 yrs</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5 MEEM AVE.</u>	
3. NAME OF DECEASED (Type or print) <u>NANCY</u> First <u>WALLACE</u> Middle <u>WARNER</u> Last		4. DATE OF DEATH <u>Aug 18</u> 19 <u>58</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 31, 1885</u> 72 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>KEEN, Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>REV. WM WALLACE</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET ELDER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>REV. J. O. WARNER</u> Address <u>5 MEEM AVE. GAITHERSBURG, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u>			
440x DUE TO (b) <u>Chronic Myocarditis</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Hypertension Arteriosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1955</u> 19 <u>55</u> to <u>Aug. 18</u> 19 <u>58</u> , that I last saw the deceased alive on <u>Aug. 18</u> 19 <u>58</u> , and that death occurred at <u>1:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Luciano I. Leal</u> M.D.		ADDRESS (Street, city or town, state) <u>GaitHERSBURG MD.</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Luciano I. Leal M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/22/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>	22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>THE S. H. NIVESCO</u> ADDRESS <u>3901 14th St N.W. WASHINGTON D.C.</u>		24a. REC'D BY REGISTRAR <u>DATE AUG 20 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>



CERTIFICATE OF DEATH

09337

Reg. Dist. No.

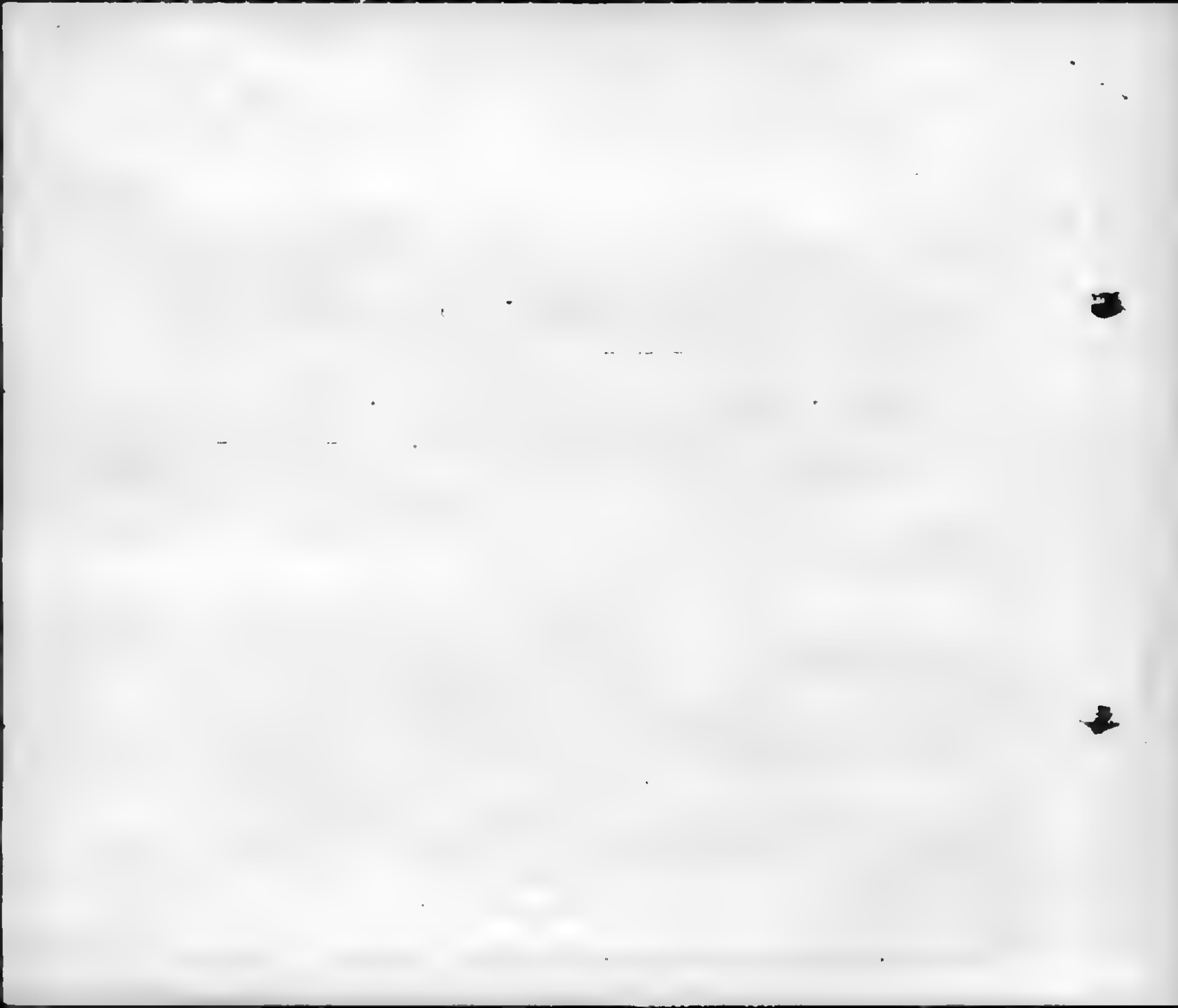
9342

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3903 Leland Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FLORENCE Middle B Last WEBB				4. DATE OF DEATH Month August Day 5 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 11, 1870	
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months 11 Days 25 Hours Min. 		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Vermont	
12. CITIZEN OF WHAT COUNTRY? US							
13. FATHER'S NAME Samuel H. Brooks				14. MOTHER'S MAIDEN NAME Emma L. Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO 578-46-6110B			
17. INFORMANT DeWitt C. Webb-husband-same as 2b				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemiplegia, rt. severe DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalised DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 4 days. 5 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Auricular Fibrillation with congestive failure							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from AUG 1 , 19 58 , to AUG 5 , 19 58 , that I last saw the deceased alive on AUG 5 , 19 58 , and that death occurred at 9:30 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Stewart Clapp				ADDRESS (Street, city or town, state) 3921 Ingomar St NW 4			
DATE SIGNED 7-5-58							
PHYSICIAN'S NAME (Type) Stewart Clapp				Wash 15 D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 8/8/58		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR AUG 11 '58	
				24b. REGISTRAR'S SIGNATURE Overman			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached from this as the burial-transit permit. Then please remove carbon paper from pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9343

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>5 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>4413 Everett St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Jacob</u> Last <u>Weber</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>15</u> Year <u>1958</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 1, 1877</u>	9. AGE (In years, lost birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Joseph Weber</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Shumcher</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Ralph Weber</u> Address <u>4413 Everett St. Kensington, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebrovascular accident</u> DUE TO (c) <u>Cerebrovascular arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>June 1958</u> <u>Aug 1958</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u>58</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>58</u> , to <u>Aug. 14</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Aug. 14</u> , 19 <u>58</u> , and that death occurred at <u>8:40</u> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Charles P. Hueston</u> M.D.				PHYSICIAN'S NAME (Type) <u>Lee Funeral Home</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Aug. 18/58 Fort Lincoln</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Bladenburg</u>		22d. LOCATION (City, town, or county) (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Wm. Lee</u>				ADDRESS <u>4th & Mass. ave. N.E.</u>		24. REC'D BY REGISTRAR DATE <u>AUG 19 58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles E. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon 4. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9344

CERTIFICATE OF DEATH

Reg. Dist. No.

09339
215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) o. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 2 Hr. 35 min	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Middle Girl Last WELLS		4. DATE OF DEATH Month August Day 4 Year 19 58	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 August 1958
9. AGE (In years last birthday) yrs. 12 Months 59		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Oscar A. WELLS		14. MOTHER'S MAIDEN NAME Gloria Ann CAMPBELL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Official Navy Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Primary Atelectasis, bilateral DUE TO Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prematurity DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 12 hrs 12 hrs 55 min
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4 August 19 58 to 4 August 19 58 , that I last saw the deceased alive on 4 August 19 58 , and that death occurred at 3:05 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE J. C. Parke		DATE SIGNED 8-7-58	
PHYSICIAN'S NAME (Type) J. C. PARKE, JR. LT, MC, USN		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL, (Specify) Burial		22b. DATE THEREOF 8-8-58	
22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Lexington Park, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Mattingly, Leonardtown, Maryland		24a. REC'D BY REGISTRAR LUG 8 '58	
24b. REGISTRAR'S SIGNATURE W. J. Seach			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9196

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>10609 Lorain Avenue</u>	
8. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u>		d. STREET ADDRESS <u>10609 Lorain Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>White, Claude</u>		4. DATE OF DEATH Month <u>August</u> Day <u>19</u> Year <u>1958</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-12-86</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>minister</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Clergy</u>	
13. FATHER'S NAME <u>Milo White</u>		14. BIRTHPLACE (State or foreign country) <u>Michigan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>—</u>	
17. INFORMANT <u>Hospital Records</u>		18. ADDRESS <u> </u>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE EDEMA OF THE LUNGS</u> <u>570.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ACUTE PELVIC PERITONITIS</u> DUE TO (c) <u>ACUTE INTESTINAL OBSTRUCTION</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2-3 DAYS</u> <u>5 DAYS</u> <u>5-7 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS, POSTENCEPHALITIC PARKINSONISM</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>18 AUG. 1958</u> to <u>19 AUG. 1958</u> that I last saw the deceased alive on <u>18 AUG. 1958</u> and that death occurred at <u>5 AM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>9013 FLOWER AVE SILVER SPRING, MD</u>	
ACTUAL SIGNATURE <u>L.B. Snow</u>		DATE SIGNED <u>8/19/58</u>	
FURNER'S NAME (Type) <u>L.B. SNOW</u>		22a. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Mausoleum</u>	
22b. DATE THEREOF <u>Aug. 22, 1958</u>		22c. LOCATION (City, town, or county) (State) <u>Prince Geo. Co. Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Walters</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 21 '58</u>	
ADDRESS <u>254 Carroll Dr NW DC</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Walters</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After a certificate has been signed by the attending physician and completed, pages 1 and 2 should be filled in by the funeral director, page 3 should be detached for the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9345

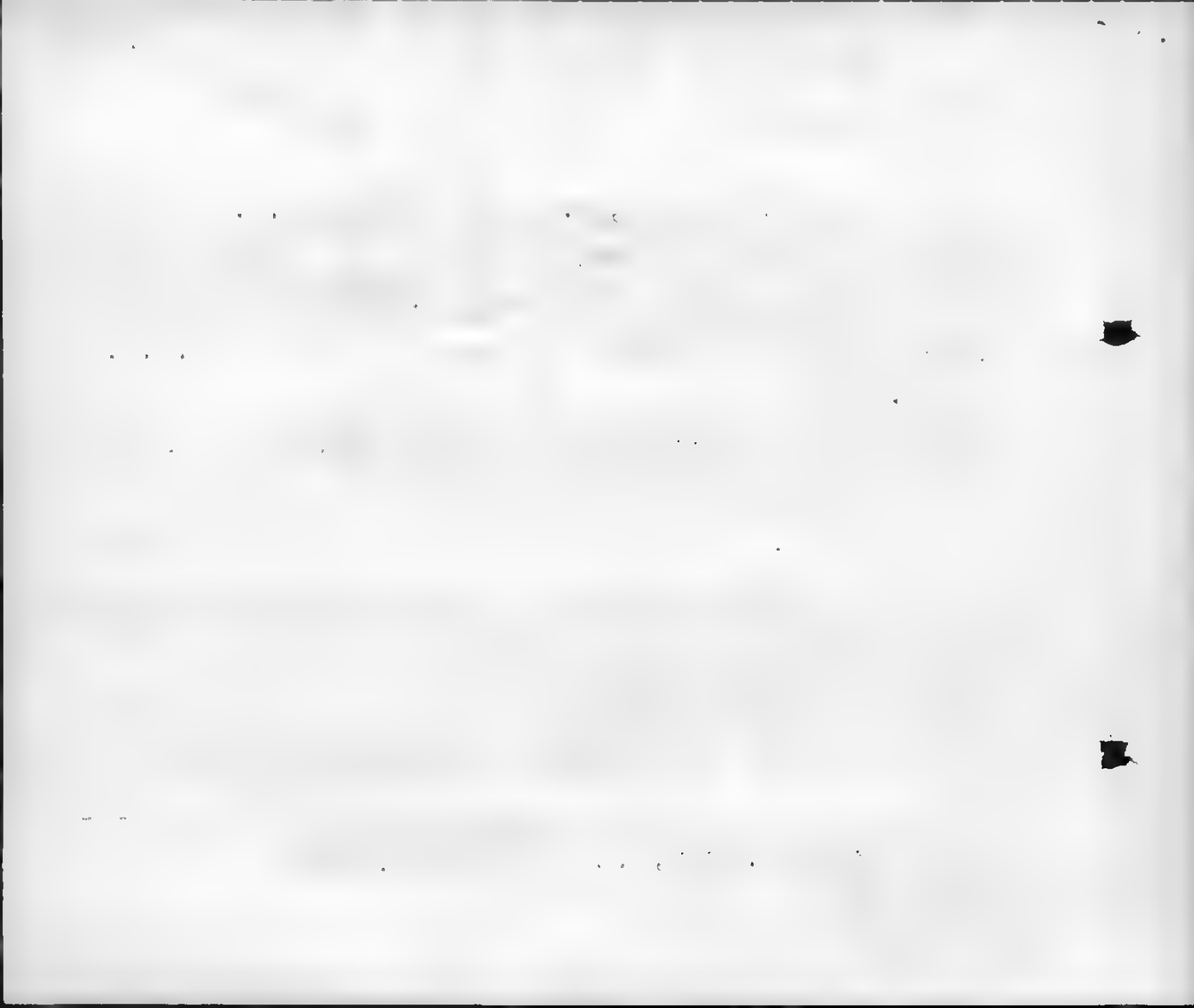
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
c. LENGTH OF STAY IN 1b 121 days		d. STREET ADDRESS 3720 Upton Street, N. W.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Marie TTA (Name) J Wilde		4. DATE OF DEATH Month Day Year August 14 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH January 24, 1889
9. AGE (In years last birthday) 69		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Broker		10b. KIND OF BUSINESS OR INDUSTRY Real Estate	
11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Arthur W. Jones		14. MOTHER'S MAIDEN NAME Lenora Hawkes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) No		16. SOCIAL SECURITY NO Unascertainable	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma 1944 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of thyroid DUE TO AND Congestive heart failure		INTERVAL BETWEEN ONSET AND DEATH 1 Mo Yrs Hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 15, 1958 to August 14, 1958 , that I last saw the deceased alive on August 14, 1958 , and that death occurred at 6:21 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland DATE SIGNED 8-15-58			
ACTUAL SIGNATURE Mitchell T. Rabkin M.D.			
PHYSICIAN'S NAME (Type) Mitchell T. Rabkin, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8-18-58	
22c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN		22d. LOCATION (City, town, or county) (State) BLADENSBURG MD	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. CHAMBERS CO		ADDRESS 1400 Chapin St. N.W.	
24a. REC'D BY REGISTRAR AUG 18 '58		24b. REGISTRAR'S SIGNATURE Carlton E. Hume	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon and file in the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9197

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09342

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON SAN. AND HOSPITAL</u>				d. STREET ADDRESS <u>7907 GARLAND AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>W</u> Last <u>WILLIAMS</u>				4. DATE OF DEATH Month <u>AUGUST</u> Day <u>15</u> Year <u>1958</u>			
5. SEX <u>FE</u>	6. COLOR OR RACE <u>WH.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-25-1898</u>		9. AGE (In years last birthday) <u>60</u> yrs.	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>POSTED PATH</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Medical</u>		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>DANIEL WEAVER</u>				14. MOTHER'S MAIDEN NAME <u>FRANCIS AVKER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>DAUGHTER</u> Address <u>SAME</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid Hemorrhage</u> 30X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arterio Sclerosis</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>24 hr.</u> <u>20 hr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month, Day, Year <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John G. Ball</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>15 Aug 58</u>			
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 19, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pike Memorial Church Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Ephrata Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Wector</u>				ADDRESS <u>254 Carroll St NW DC</u>		24a. READ BY REGISTRAR Date <u>AUG 19 58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

TO MEDICAL EXAMINER: This certificate should be submitted within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the Registrar prior to burial, cremation, or removal.



9346

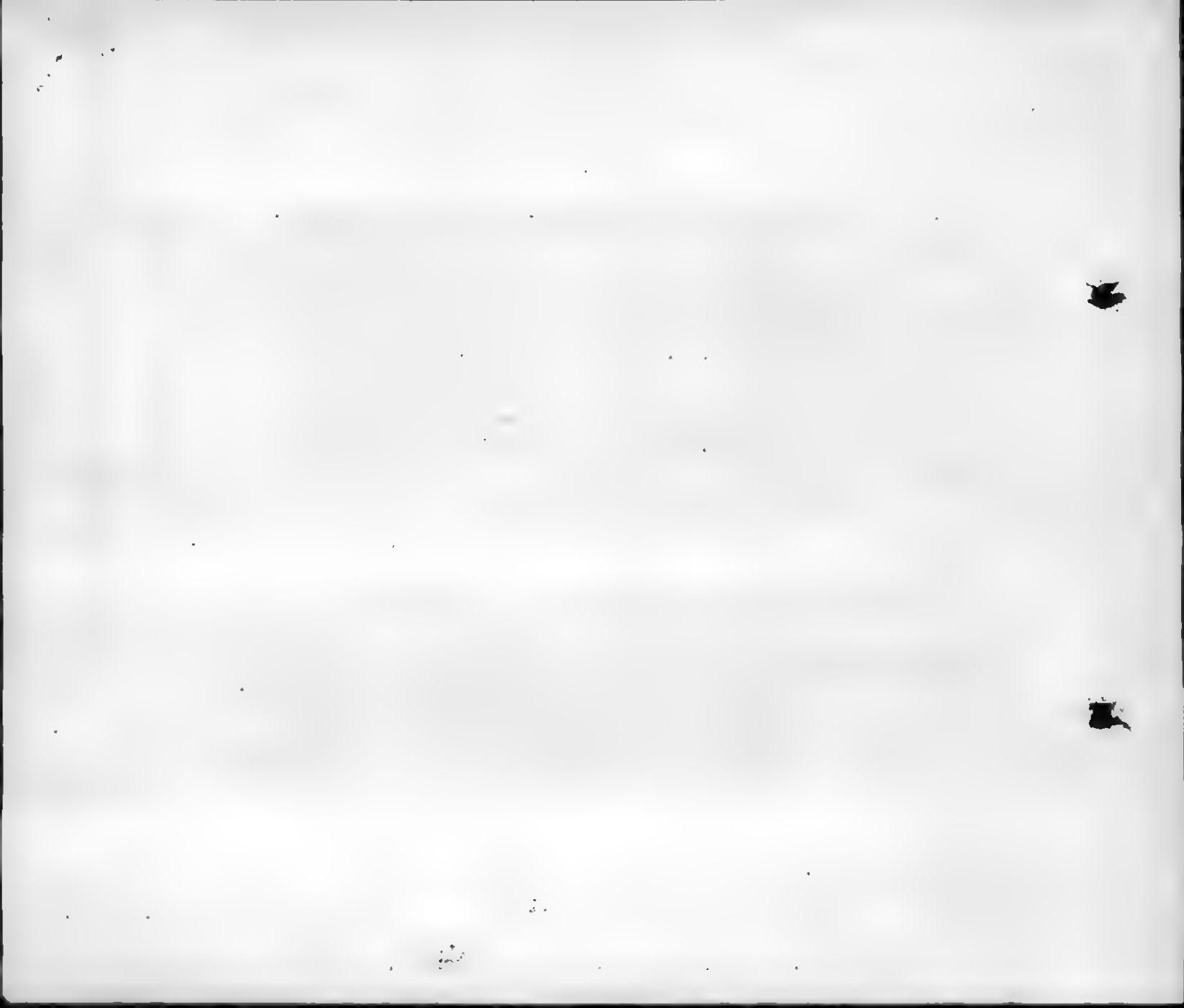
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist No 215

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 28 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital, NMMC, Bethesda, Md.			2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park / / d. STREET ADDRESS 42 Philadelphia Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Jackie Terry WILLIAMS			4. DATE OF DEATH Month Day Year August 10 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 21, 1937	9. AGE (In years last birthday) 20 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 20 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaman		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) W. Virginia	
13. FATHER'S NAME Albert WILLIAMS			14. MOTHER'S MAIDEN NAME Lucille MC KEEHAN		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) yes 1-17-55 to pres.		16. SOCIAL SECURITY NO. 379 36 0931		17. INFORMANT Official Navy Records Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fractures of 5th & 6th Cervical with injury to cord 28 days DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Dived from pier and struck sunken obstruction.			
20c. TIME OF INJURY Month, Day, Year 6:00 Hour 7-13 1958	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Breezy Point Beach		20f. (City or town) (County) (State) Breezy Point Calvert Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Frank J. Broschart</i> EXAMINER'S NAME (Type) Frank J. BROSCHART		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 8-10-58	
22a. BURIAL CREMATORY, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-15-58		22c. NAME OF CEMETERY OR CREMATORY Jellico Cemetery	
22d. LOCATION (City, town, or county) (State) Jellico, Campbell Co., Tenn.		23. FUNERAL DIRECTOR'S SIGNATURE <i>W. W. Chambers</i> ADDRESS W. W. CHAMBERS CO., 1400 Chapin St., NW, Washington, D. C.			
24a. REC'D BY REGISTRAR AUG 11 1958		24b. REGISTRAR'S SIGNATURE <i>Arthur A. Kruetz</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 1 could be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper between pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9198

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09344

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>		c. LENGTH OF STAY IN 1b <u>18 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Baby Boy</u> First <u>Wilson</u> Middle <u>Wilson</u> Last <u>Wilson</u>		4. DATE OF DEATH <u>August 2 1958</u> Month <u>August</u> Day <u>2</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-1-58</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>1 day</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Roger Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Ruth Grace Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Father</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congenital Heart Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>32 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>8-1</u> , 19 <u>58</u> , to <u>8-2</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8-2</u> , 19 <u>58</u> , and that death occurred at <u>4:20 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stanley L. Wise</u>		ADDRESS (Street, city or town, state) <u>2322 Blue Ridge Pk., Silver Spring, Md.</u>	
PHYSICIAN'S NAME (Type) <u></u>		DATE SIGNED <u>8-2-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Disposal</u>	22b. DATE THEREOF <u>8-2-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>by Wash. San. & Hosp.</u>	22d. LOCATION (City, town, or county) (State) <u>Takoma Park, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u></u> ADDRESS <u></u>		24a. REC'D BY REGISTRAR <u></u> 24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u>	
		DATE <u>AUG 8 '58</u>	

2075314XV



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09345

9347

CERTIFICATE OF DEATH

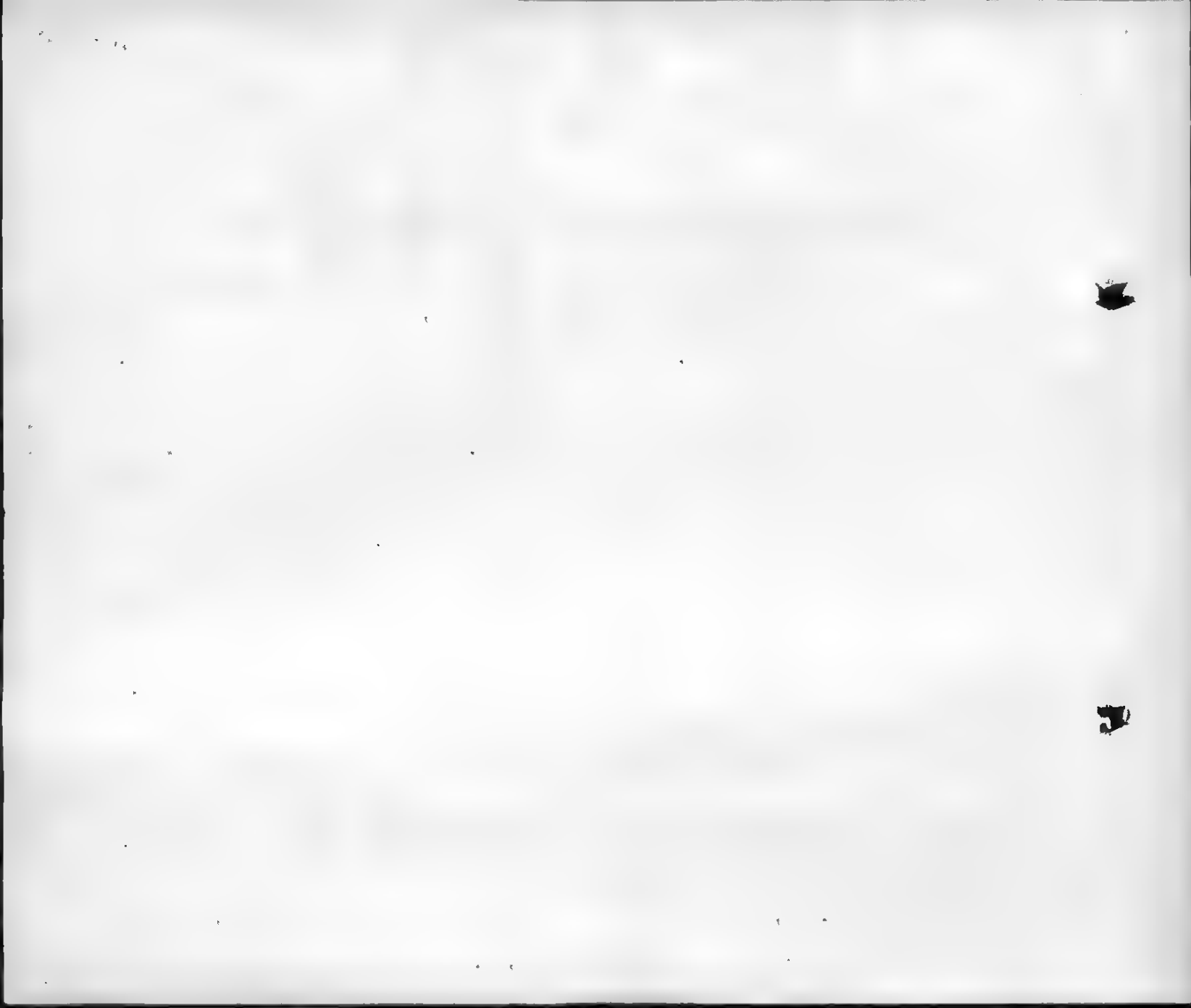
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 30 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		d. STREET ADDRESS 814 SILVER SPRING AVENUE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 814 SILVER SPRING AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) CHARLES GEORGE WINSLOW		4. DATE OF DEATH Month AUGUST Day 19 Year 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 8, 1894
9 AGE (In years last birthday) 63 yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) butcher		10b. KIND OF BUSINESS OR INDUSTRY Dist. Grocery Store	11. BIRTHPLACE (State or foreign country) Russia
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME unknown	
14. MOTHER'S MAIDEN NAME unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. 577-09-9196		17. INFORMANT Arthur J. Williamson Address 5427 Taney Dr. Alexandria, Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriosclerosis and Hypertensive Cardiovascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Four Small Cerebral Vascular Accidents			INTERVAL BETWEEN ONSET AND DEATH about 10 minutes
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9/25 , 19 57 , to 8/19 , 19 58 , that I last saw the deceased alive on Dec 2 , 19 57 , and that death occurred at 6:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Benjamin Isaacson M.D.		DATE SIGNED 8/19/58	
PHYSICIAN'S NAME (Type) Benjamin Isaacson		ADDRESS (Street, city or town, state) Washington, D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 21, 1958	22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven	22d. LOCATION (City, town, or county) (State) Silver Spring, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Wernse C. Pumphrey		ADDRESS Silver Spring, Md.	
24a. REC'D BY REGISTRAR AUG 20 '58		24b. REGISTRAR'S SIGNATURE Arthur J. Thomas	

Ass't Medical Examiner Notified and will approve.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for the burial-transit permit. Then please remove carbon copy of pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

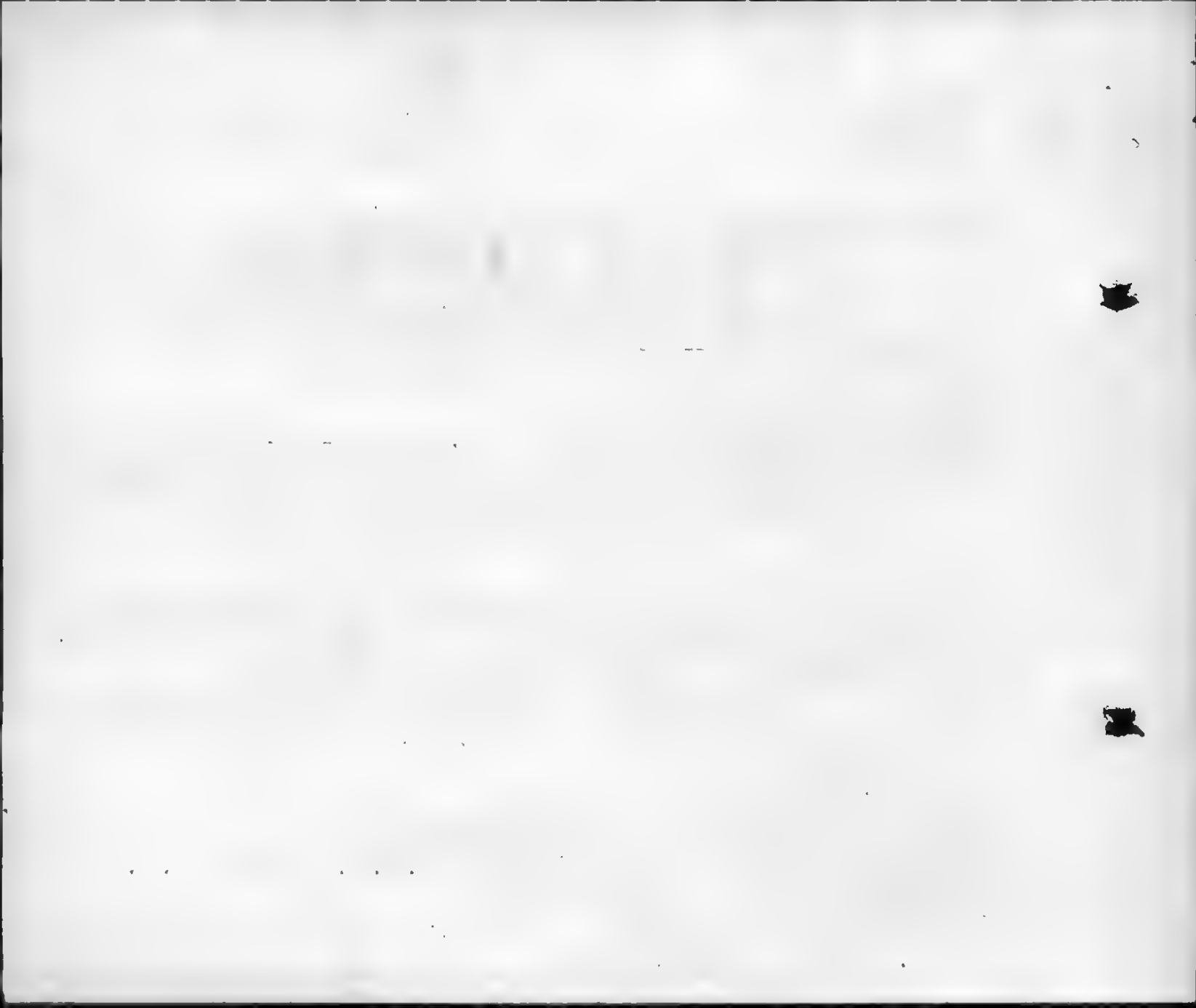
9348

CERTIFICATE OF DEATH

Reg. Dist. No.

09346

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. LENGTH OF STAY IN 1b 			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Rest Home				e. STREET ADDRESS 33 Quincu Street			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First AGNES Middle MAE Last WOLFINGER				4. DATE OF DEATH Month August Day 13 Year 1958			
5. SEX Fe		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 15, 1884	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months 0 Days 28		IF UNDER 24 HRS Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Iowa	
12. CITIZEN OF WHAT COUNTRY? US							
13. FATHER'S NAME Andres Sonerson				14. MOTHER'S MAIDEN NAME Louisa Anderson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Carroll M. Wolfinger-sonc-same as 2 d			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) generalized arteriosclerosis DUE TO (c) 							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatoid arthritis							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) 				(County) 		(State) 	
21. I certify that I attended the deceased from OCT. 5 , 19 57 , to August 13, 1958 , that I last saw the deceased alive on August 12, 1958 , and that death occurred at 2 A M., from the causes and on the date stated above.							
ACTUAL SIGNATURE E. W. Nealon Jr. M.D.				ADDRESS (Street, city or town, state) 8/13/58			
DATE SIGNED							
PHYSICIAN'S NAME (Type) Stephen W. Nealon Jr.				1746 K St. N. W. Washington, D. C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit		22b. DATE THEREOF 8/13/58		22c. NAME OF CEMETERY OR CREMATORY Glendale Cemetery		22d. LOCATION (City, town, or county) (State) DesMoins, Iowa	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR AUG 14 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus							



9349

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 9 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Brooke Grove Nursing Home				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lewis Middle Wooten Last Wooten				4. DATE OF DEATH Month August Day 13 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/9/73	
9. AGE (In years last birthday) 85 yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (Retired)				10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John Henry Wooten				14. MOTHER'S MAIDEN NAME Margaret Elizabeth Mitchell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Hospital Records Olney, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Heart Disease 904.0 DUE TO Parkinson's Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Fracture left hip (b) Fracture left hip (c) Fracture left hip INTERVAL BETWEEN ONSET AND DEATH 14 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell at home fracture neck left femur			
20c. TIME OF INJURY Month Day Year Hour a. m. 10:30 p. m. 58				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home				20f. (City or town) (County) (State) Peptonville Montgomery Md			
21. I certify that I attended the deceased from 7/39 19 58 to 8/13 19 58 that I last saw the deceased alive on 8/11 19 58 , and that death occurred at Peptonville , from the causes and on the date stated above.							
ACTUAL SIGNATURE Mair				DATE SIGNED 8/13/58			
PHYSICIAN'S NAME (Type) J. W. Bird, M. D.				ADDRESS (Street, city or town, state) Sandy Spring, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Aug 15, 1958				22b. DATE THEREOF Aug 15, 1958			
22c. NAME OF CEMETERY OR CREMATORY Louis Hill Cem				22d. LOCATION (City, town, or county) (State) Laurel Md			
23. FUNERAL DIRECTOR'S SIGNATURE DeWitt Canaldon, Laurel, Md				24a. REC'D BY REGISTRAR DATE AUG 20 '58			
24b. REGISTRAR'S SIGNATURE C. H. S. H. H.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9350

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 19 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.				d. STREET ADDRESS Box 77, Route #2			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Howell Middle Louis Last Worthington				4. DATE OF DEATH Month August Day 9 Year 19 58			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 3, 1899	
9. AGE (in years last birthday) 59 yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS Months _____ Days _____ Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Louis Worthington				14. MOTHER'S MAIDEN NAME Susie Hammond			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT Hospital Records				Address _____			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro Vascular accident							
DUE TO (b) hypertension and arteriosclerosis							
DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from July 21, 1958 , to August 9, 1958 , that I last saw the deceased alive on August 9, 1958 , and that death occurred at 3:10 p. m. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE Bertrand R. Goss M.D. Sykesville, Maryland							
PHYSICIAN'S NAME (Type) B. R. Goss, M. D., Sykesville, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 8-13-58			
22c. NAME OF CEMETERY OR CREMATORY Bushy Park				22d. LOCATION (City, town, or county) _____ (State) _____ Crooksville, Howard, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Ruthie H. Haight				24a. REC'D BY REGISTRAR AUG 18 '58			
ADDRESS Sykesville, Md.				24b. REGISTRAR'S SIGNATURE Arthur S. Evans			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached and used as the burial-transit permit. Then please remove carbon copy.



9351

CERTIFICATE OF DEATH

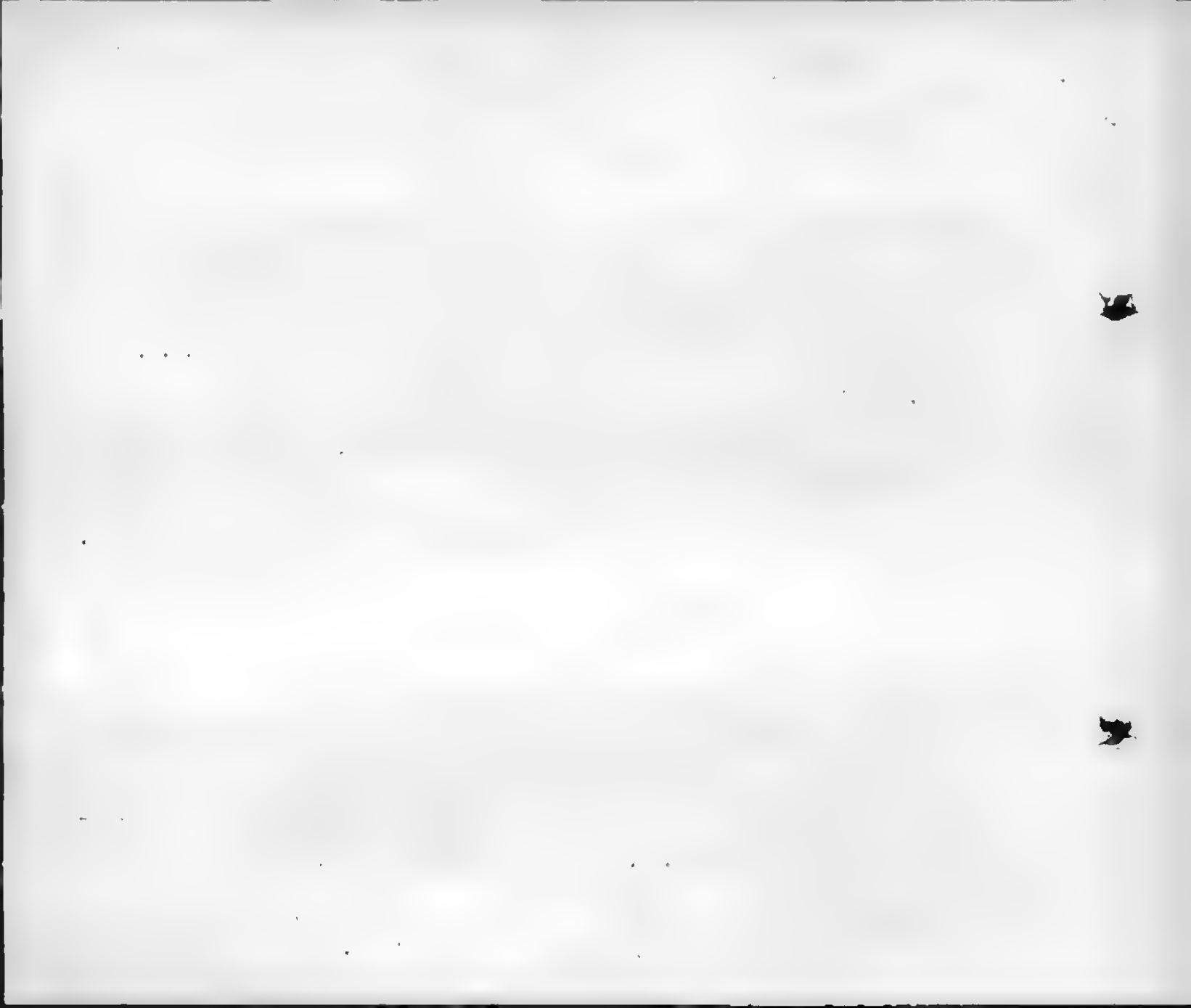
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN TB 26 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center				d. STREET ADDRESS 12017 Ashley Drive			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Jettye Middle Ellen Last Wyatt				4. DATE OF DEATH Month 22 Day August Year 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 26, 1889	9. AGE (In years last birthday) 69 yrs	IF UNDER 1 YEAR Months 69 Days 0 Hours 0 Min 0	IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher			10b. KIND OF BUSINESS OR INDUSTRY Education		11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME David W. Gilliam				14. MOTHER'S MAIDEN NAME Ellen Pace			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute myelocytic leukemia DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH 1 day 2 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 27 , 19 58 to August 22 , 19 58 , that I last saw the deceased alive on August 22 , 19 58 , and that death occurred at 11:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 8-23-58 ACTUAL SIGNATURE Habeeb Bacchus M.D. The Clinical Center PHYSICIAN'S NAME (Type) Habeeb Bacchus, M. D. National Institutes of Health Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 8/23/58		22c. NAME OF CEMETERY OR CREMATORY Maple Lawn Park		22d. LOCATION (City, town, or county) (State) Paducah, Kentucky	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland				24a. REC'D BY REGISTRAR DATE AUG 25 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached from the certificate and retained by the funeral director. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and carefully filled in by the funeral director, page 3 should be detached from this certificate and taken to the funeral home. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09350

9352

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 5 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9813 ROSENSTEEL AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HERBERT Middle OSBORNE Last YARDLEY		4. DATE OF DEATH Month AUGUST Day 7 Year 58	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/13/89
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WRITER AND AUTHOR		10b. KIND OF BUSINESS OR INDUSTRY WORTHINGTON, INDIANA	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ROBERT KIRKBRIDE YARDLEY		14. MOTHER'S MAIDEN NAME MARY EMMA OSBORNE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give year or dates of service) WW #1		16. SOCIAL SECURITY NO. 215-26-3709	
17. INFORMANT Mrs. Edna R. Yardley, 9813 Rosensteel Ave.		Address Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 7 days (c) years		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Silver Spring, Md.		(County) (State)	
21. I certify that I attended the deceased from Feb 2 1958 to Aug 7, 1958 that I last saw the deceased alive on Aug 7, 1958 and that death occurred at 1:15 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10620 Georgia Ave Silver Spring, Md DATE SIGNED 8/7/58			
ACTUAL SIGNATURE John J. Curry M.D.		PHYSICIAN'S NAME (Type) JOHN J. CURRY	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 8/11/58	22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY	22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA
23. FUNERAL DIRECTOR'S SIGNATURE Walter B. Humphrey		ADDRESS SILVER SPRING, MD.	24a. REC'D BY REGISTRAR DATE AUG 11 '58
		24b. REGISTRAR'S SIGNATURE W. Beach	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

DECEASED
NAME
AGE
SEX
RACE
BORN
DIED
PLACE
CITY
COUNTY
STATE

1. Name of deceased
2. Age at death
3. Sex
4. Race
5. Date of death
6. Place of death
7. City
8. County
9. State
10. Cause of death
11. Signature of physician
12. Signature of registrar
13. Date of registration

CERTIFICATE OF DEATH

09351

Reg. Dist. No.

9353

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN TB <u>15 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>19302 Sutton Pl.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) (also known as <u>Annie</u>) <u>Anna Catherine Young</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>3</u> Year <u>1958</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 28, 1877</u>	
				9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Fleishell</u>				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>577-10-5191 D</u>		17. INFORMANT <u>Eugene W Young, 9300 Sutton Pl. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>56</u> , to <u>Aug 3</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Aug 3</u> , 19 <u>58</u> , and that death occurred at <u>9:05</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>9241 Col. Blvd.</u> DATE SIGNED <u>8/3/58</u>							
ACTUAL SIGNATURE <u>Marion Bankhead</u> M.D.							
PHYSICIAN'S NAME (Type) <u>J. Marion Bankhead</u>				<u>Silver Spring, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>8/7/58</u>		<u>ST. JOHN'S CEMETERY</u>		<u>MONTGOMERY COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner G. Humphrey</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR	
				DATE <u>AUG 7 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon page 4. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

